WASHINGTON STATE PLANNING GRANT
ON
ACCESS TO HEALTH INSURANCE

REPORT to the SECRETARY

Submitted to:

U.S. Department of Health and Human Services
Health Resources and Services Administration

State Planning Grant #1 P09 OA 00002-01-05

September 30, 2004

Project Staff:
Vicki M. Wilson, Ph.D.: (Phone: 360-902-0652; Email: vicki.wilson@ofm.wa.gov)
Mich'l Needham, MPA: (Phone 360-902-0664; Email: mich'l.needham@ofm.wa.gov)
Jenny Hamilton, MSG: (Phone 360-902-0634; Email: jenny.hamilton@ofm.wa.gov)

Making Health Care Work for Everyone

Washington State
HRSA State Planning Grant on Access to Health Insurance
Report to the Secretary: 2003 Continuation Grant

EXECUTIVE SUMMARY

Washington's State Planning Grant Program

Washington received its first State Planning Grant (SPG) in March 2001.[1] Two continuation grants (in 2002 and 2003) have created an enduring spotlight in the Governor's Office on the uninsured.

Consistent with federal program goals of profiling the uninsured and supporting efforts to develop health insurance coverage options, Washington's SPG has focused on four areas:

- *"launching pad" research* (e.g., identify gaps, overlaps and barriers to coverage based on detailed profiles and affordability analyses; stimulate discussion by articulating a set of potential policy options for enhancing coverage);
- *technical data improvements* (e.g., address "Medicaid undercount" issues in the state population survey; integrate coverage and access data sources; minimize incorrect use of survey data);
- *neutral, expert resource and "voice"* on Washington's uninsured (e.g., act as clearinghouse to answer questions on the uninsured and who's doing what to address various issues; raise level of understanding and influence thinking in Governor's policy and budget offices); and,
- *policy and evaluation assistance* on coverage- and access-related activities (e.g., impacts of public program cost-sharing changes; Governor's rural access package; community development of low-income coverage strategies; safety net and public program dependencies; impacts of proposed policy changes on employer coverage offerings).

A history of Washington's SPG program is given in Figure ES-1.

In the remainder of this executive summary we: (1) review Washington's economic and political environment, (2) provide an update on covering Washington's uninsured, and (3) preview the content of our Report to the Secretary.

An Environment for Change?

Washington's SPG program has existed during challenging times. Simultaneous with receipt of the initial grant in 2001, Washington's economy and state budget were hit hard by recession. In fact, within days of receipt of the grant we got an inkling of things to come – an inquiry from legislative staff wondering if we'd lost our marbles talking about coverage expansion when the state couldn't afford to cover people already on its programs![2]

Three-plus years later the economy is looking up. For example, the state's latest forecast indicates a small increase in revenue available to the 2004 Legislature as it decides the 2005-07 biennial budget. However, least we get too optimistic the 05-07 general fund budget deficit is still pegged at around $1.1 Billion dollars[3]. In addition, the state's Health Services Account (HSA), which funds many of

[1] The State Planning Grant program is funded by the U.S. Department of Health & Human Services, Health Resources and Services Administration, Bureau of Professions.
[2] It is interesting that the assumption made was that coverage expansion would automatically mean public program expansion.
[3] As of July 2004, the Governor's Office of Financial Management was estimating revenue of $24.75 billion and expenditures of $25.85 billion for the 2005-07 biennium. These numbers are constantly being reworked and are solely intended to give an "order of magnitude" sense of status.

Washington's health coverage and access programs, is also projected to be in the red – the current estimate is a deficit of over $80 million for 05-07.

On the employment side, things are improving as well, but somewhat slowly. After recession high unemployment rates above seven percent, Washington's 2004 rate (August) is just over six percent. Again, least we get too optimistic it's probably not safe to assume that as jobs return coverage will necessarily return with them. Consider the potential implications of the following combination of factors: (1) a continuous decline in employer-based coverage in Washington for the last 10 years, (2) the changing face of employment as full-time jobs give way to contract, multiple-employer, part-time, and often lower-paying jobs[4] that frequently don't include health insurance, and (3) the continuing pressure of health care inflation that makes it increasingly difficult for employees to take-up the coverage offered by their employers.

On the political front, the previous environment for the SPG has been relatively free of major upheavals; where changes have occurred they often have been overshadowed by the dire condition of the economy and state budget. However, in the future we will be working in a changed political context. In January 2005 Washington will have a new Governor. Both major party candidates highlight health care in their campaigns, although with different areas of emphasis and different perspectives on what is needed to address the growing number of uninsured Washingtonians. In addition to a new Governor, there potentially will be new faces, philosophies, and leadership in the Legislature as all members of the House and one-half the Senate are up for election in November 2004.

Needless to say, the challenges and opportunities to meet the Washington SPG program goals of "making health care work for everyone" and "covering the uninsured" continue.

Coverage Update: A Leader Falters[5]

In the 1980's and 1990's Washington was a leader on many coverage fronts – expansion of coverage for low-income working (Basic Health) and for children and their families (Medicaid coverage for children up to 200% federal poverty before SCHIP); pre HIPAA market reforms; early adoption of a high risk pool; sweeping health care reform to achieve universal coverage (subsequently repealed); dedication of tobacco litigation dollars to health care (with an emphasis on prevention). Coverage steadily increased.

More recently, Washington has lost ground. The state's overall uninsured rate rose from 7.7% in 2000 to 8.4% in 2002. Coverage via an employer has steadily eroded for the under-65 population, dropping from 70.9% in 1993 to 66.5% in 2002. Coverage for children has taken a turn for the worse. Although 2002 data show an impressively low uninsured rate for children (0-18) of 4.5%, public program changes since 2002 have altered the picture. Estimates of the number of children who have lost coverage vary but are in the thousands and we presume (although don't know for sure) that many of these children are now uninsured. Responses to the 2004 state population survey

[4] Notwithstanding that definitions of "living wage" can be argued, one recent source finds that "Of all job openings [in Washington], 26 percent pay less than the $10.07 an hour living wage for a single adult. Seventy-seven percent pay less than the $20.97 an hour living wage for a single adult with two children." *Searching for Work That Pays: 2004 Northwest Job Gap Study*, Northwest Federation of Community Organizations and Paul Somers, 2004 .

[5] Figures cited in this section are primarily from the 2000 and 2002 Washington State Population Surveys.

are currently being cleaned and coded; data will be available in late Fall to better assess the current status of coverage.[6]

Given the environment described earlier, state policy vis-à-vis coverage has focused most recently on (1) maintaining existing public programs for the most vulnerable, (2) providing a supportive environment for employers to offer coverage and individuals to purchase it, and (3) assisting the clinic-based safety net system with funds and regulatory support. Notwithstanding these efforts, people unfortunately have still lost coverage, most notably in public programs – immigrant children were moved from Medicaid to Basic Health and did not re-enroll as hoped, Basic Health coverage slots were decreased and funded by dollars intended (via a citizen's initiative) for expansion, Medicaid administrative changes resulted in much larger than anticipated exits of children, major changes to Basic Health cost-sharing (including deductibles and co-insurance) were implemented (evaluation of impacts is underway).

However, there also have been a few recent "incremental" bright spots including coverage for the working disabled, opening Basic Health to people eligible for Trade Act coverage, resolving an individual market collapse, forestalling a small group market "affordability" crisis, and Governor Gary Locke's decision to delay until July 2005 premiums for some Medicaid children (those below 200% federal poverty); although children in SCHIP (201% - 250%) saw an increase in premium sharing effective July 2004.

All in all, the mixture of Washington's progressive social policy, conservative fiscal policy (e.g., 1993 passage of spending cap), and recent economic downturn has produced a current "health system for low-income individuals [that] seems to be in a fairly fragile state".[7]

The irony of working on a grant to achieve broader coverage, simultaneous with watching the uninsured rate increase, does not escape us. It has been an on-going challenge.

Lessons from SPG's Three Years

While we have learned many "factual" things (which are the focus of our report) over the last few years of the SPG, we want to embrace this opportunity to make the following "value-based" observations.

- Our most important lesson as we researched, discussed, and debated covering the uninsured and did so during a prolonged period of state recession and increasing health care costs is this: ***If we fail to reserve during the good times the financial resources to maintain and enhance public funding and programs during the bad times we have failed our residents most miserably.*** It is during times of economic downturn that government assistance is most needed, not only for those traditionally defined as most vulnerable but also for those who find themselves in temporary, but nonetheless devastating need.

[6] The state population survey captures insurance status at a point in time. There are various accepted, but different, ways of measuring how many people are uninsured – point in time, for an entire year, during any time period within a year (or over several years). The array of numbers can be mind-boggling and it often appears that much time is spent searching for the number that supports a position. Perhaps the most useful point of view is this: All estimates are wrong, some are useful, most tell a consistent and compelling story about the level (or lack thereof) of access to coverage.

[7] Holahan, John and Mary Beth Pohl. 2002. "*Recent Changes in Health Policy for Low-Income People in Washington*." Washington, D.C.: The Urban Institute. The quote used is as true today as it was when Holahan & Pohl wrote it.

- Second, we suggest a restatement of the end-game – the end-game is not about insurance, it is about a healthy, productive (in all respects, not just economically) population. In this latter view, everyone benefits -- communities, governments, businesses, individuals -- and the discussion centers on where to draw the line between ***what in health care is a social good for which we take societal responsibility (such as we do in basic education) and what in health care is a "commodity" to which some people may have access and others may not.***

- Finally, even if there is no universally acceptable one-size fits all solution[8], there certainly are some "truisms" that repeat themselves time and again. One of the most persistent is that low-income people need substantial subsidies in order to afford coverage that offers any reasonable measure of health and financial security. Aligned with this, due in large part to the subsidy issue, is that public programs are very effective in meeting the coverage needs of the low income. Washington has already made consistent *policy* decisions regarding who needs help: adults to 200% and children to 250% of federal poverty. ***Surely, if it is the right policy decision then it should also be the right budget decision – to search out all who are eligible, subsidize their coverage, and reduce the number of uninsured in Washington by over two-thirds.***

Report Preview

The remainder of this Report to the Secretary is organized as requested. In Sections 1 –3 we discuss data collection and analysis activities related to profiling uninsured individuals and families, employer-based coverage, and Washington's health care market place. During this last grant cycle we spent considerable time updating our information on the uninsured based on 2002 State Population Survey data. There were few surprises from what the 2000 data showed – Washington's uninsured are members of working families, and are poor, young, and often without dependent children. There continue to be disparities in coverage, with the highest rates occurring among Hispanics and American Indians/Alaskan Natives. Middle-income families are feeling the pinch and make up a significant segment of the uninsured population. As noted earlier, we are somewhat skeptical that the low rate of uninsurance for children reflects current reality given changes to public programs that occurred post the 2002 survey. We are looking forward to seeing what the 2004 survey results will show.[9]

[8] There are multiple ways to slice and dice the uninsured population, a necessary exercise when focused on incremental, targeted strategies. A recent list includes "employees of small business, workers who lose their jobs, workers who decline employer coverage, low-income parents, low-income childless adults, the near-elderly, young adults, children, and immigrants". Dorn, S. *Towards Incremental Progress: Key Facts About Groups of Uninsured*. Economic and Social Research Institute, September 2004.

[9] Given the consistency over time of the story (if not the numbers) about who the uninsured are and their circumstances, it's fair and logical to question the usefulness of continually updating this information. We would argue its importance for two reasons: (1) what gets measured, gets changed. (2) "It is the health policy analogue of permanent military preparedness" – when policy makers are ready to act, policy analysts must be ready with up-to-date information to support breakthrough thinking. Reinhardt, U. *Is There Hope for the Uninsured?,* Health Affairs Web Exclusive, August 27, 2003.

In Section 4 we describe a select set of coverage and access activities conducted largely in 2003-04 and for which State Planning Grant (SPG) support has been important. Much of our work has been of a support nature and is somewhat difficult to capture succinctly – answering a myriad of ad-hoc questions, participating in policy and design discussions organized by a variety of groups, creating a "presence" in the executive branch to ensure that Washington's uninsured aren't lost in the shuffle of budget deficits. We do our best to show the essence of our support role but the exactness is somewhat elusive. First, we describe coverage options that have risen to the top of the *state policy* agenda (see side box). Next, we provide examples of *other activities* in Washington related to coverage and access. Finally, we highlight select examples of SPG supported work (community-based efforts; work to assess the impacts of cost-sharing changes in public programs; activities to enhance or better understand rural and safety net access; on-going administrative simplification efforts).

State Policy Agenda Most Aligned with "Covering the Uninsured"

- Cover all children
- Small employer assistance
- Employer coverage responsibilities
- Stabilize the private market
- Redesign public programs

The last section of our report is a review of our communication strategy, noting important messages about covering the uninsured. During this last grant cycle we focused significant effort on redesigning our website (our main communication tool) to make it more user friendly and, importantly, to integrate it into existing state sites as a means to ensure "life after the grant".

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

Although rates of uninsurance have varied over time, the typical profile of Washington's uninsured individuals and families remains fairly constant. They are members of working families, they are poor, young, many do not have dependent children; they are less healthy than the insured; and, regional and racial disparities are apparent. Not surprising, this picture generally mirrors the story conveyed by national surveys for most states and the nation, including reports by the United States Census Bureau[1] in August 2004. The new twist (from what we see in our historical data) is that middle-income families make up a fast growing segment of the uninsured population.

Like other states, Washington is losing ground. Although the 1990's witnessed broad success from our public coverage strategy with rates of uninsurance declining steadily for all age groups (Figure 1-1), that is now changing. With the widespread economic downturn that took hold in 2001, public program changes and steady erosion of employer-sponsored insurance have reversed the trends and uninsurance rates have begun to creep up. While the number of people with health insurance has increased more than the number without (Table 1-1), the net result since 2000 has been an increase in the proportion of the population uninsured. The uninsured rate for the total population increased from 7.7% in 2000 to 8.4% in 2002 (i.e., from about 453,000 to just over 506,000 individuals). Most people are covered by a health insurance plan related to employment, however, coverage via an employer has slowly but surely decreased for the under age 65 group, dropping from 70.9% in 1993 to 66.5% in 2002 (Figure 1-2.) Coverage for children has also taken a turn for the worse. Although 2002 data show an impressively low uninsured rate for children (0-18) of 4.5%, public program changes since 2002 have altered the picture. Estimates of the number of children who have lost coverage vary but are in the thousands and we presume (although don't know for sure) that many of these children are now uninsured. Responses from the 2004 Washington State Population Survey (WSPS) are currently being coded; data will be available in late Fall to better assess the current status of coverage.

In the following sections we describe a set of profiling activities conducted largely in 2003-2004 and for which SPG support has been essential. Our initial analysis of the uninsured provided a demographic snapshot as of 2000[2] and set a baseline for understanding who has insurance in Washington and who doesn't. More recently we focused our efforts on replicating and refining that analysis with 2002 data to build an ongoing profile of the uninsured. We have included a selection of charts and graphs[3] to help describe the characteristics of Washington's uninsured. As with much of our recent work our profiling activities have been of a supportive nature, answering questions about the uninsured and the availability and appropriate use of data sources (local data in particular), and participating in (and often instigating) efforts to improve the collection and use of local data. We have tried to capture this "clearinghouse" role for data on Washington's uninsured; it has been a challenge.

---

[1] DeNavas et al. 2004. Income, Poverty, and Health Insurance Coverage in the United States: 2003. US Census Bureau. The Census reports confirm that Washington is one of six states in the west (Alaska, Oregon, Washington, Montana, Idaho and Nevada) continuing to experience an increase in uninsurance rates.

[2] Analysis of individuals and families was primarily based on information collected biennially by Washington's State Population Survey. Results from the 2004 survey will allow comprehensive analysis over an 8-year span. Detailed information and data on all surveys are available at: http://www.ofm.wa.gov/sps/index.htm

[3] This report includes information specifically requested by HRSA. Further highlights and a more extensive array of charts, graphs and data on the uninsured are available via pull down menus on the grant project web site, http://www.ofm.wa.gov/accesshealth/accesshealth.htm

A. Profile of Washington's Uninsured Population:
Over 99% of Washington's uninsured population is under age 65. The group age 65 and older is predominantly covered by Medicare. Many live in institutions and are not included in the WSPS survey, and responses from those who are surveyed describe characteristics of this population that appear inconsistent with our administrative data. Consequently, while we continue to look for ways to improve data for the age 65 and older population, the under age 65 group has been the focus of our analysis.

Age:
Uninsurance rates vary considerably by age. Rates for children under age 19 declined from a high of 11.4% in 1993 to 4.5% in 2002, just over 73,000 children in 2002 (Figure 1-1). Rates for adults age 19-64 also declined from a high of 14.0% in 1993 to 10.0% in 2000 but then increased since 2000 to 11.5% in 2002 (Figure 1-1). Public program changes since 2002 have likely altered the picture for children and exacerbated the picture for adults – we expect 2004 WSPS data to show increased rates of uninsurance for all age groups. For example, estimates of numbers of Medicaid children who have lost coverage since summer 2002 vary; however most estimates put the number around 45,000. While some of these children have since returned to Medicaid, and a few have enrolled in Basic Health, we believe that many of them remain uninsured. The 2004 WSPS interviews were conducted in April 2004 and will likely capture the essence of changes in public program coverage.

To gain a more comprehensive picture of the uninsured we looked within these broad age groups to identify sub-groups who are disproportionately uninsured.

Since 1998, young adults aged 19 to 34 have made up the largest proportion of the uninsured, close to 45% of those uninsured under age 65 in 2000 and in 2002 (Figure 1-3.) (About 224,000 individuals). The rate of uninsurance also has steadily increased for this group. **By 2002, young adults were more than three times as likely to be uninsured as were children** (Figure 1-4) in spite of wide access to employer coverage described in section 2. Consistent with the recent release of Census data by DeNavas et al, children's gains in coverage to 2002 were more than matched by these young adults' coverage losses. Adults aged 35-54 make up the next largest segment of the uninsured. The combined group of adults age 19-54 who typically comprise the bulk of the work force now make up close to 80% of the uninsured under age 65.

National studies [4] also indicate that young adults (age 19 to 29) are one of the largest and fastest-growing segments of the population without health insurance. In Washington, although this group comprises only 16% of the under age 65 population, it makes up 36% of the uninsured. At age 19, these young adults often lose coverage under their parents' policies or are no longer eligible for Medicaid/SCHIP programs. Those that remain covered under their parents' policies while they attend college are often uninsured for a period of time immediately following graduation.

About **15% of the uninsured under age 65 are children** (Figure 1-3, 2002). Up until 2002 the distribution of uninsured children remained stable among infants, preteen school age children, and teenagers. With the decline in numbers of uninsured children in 2002, that distribution changed. The greatest reduction in uninsurance rates was felt among infants (dropping from 4.5% in 2000 to 3.3% in 2002) and teenagers in particular (dropping from 6.3% in 2000 to 4.8% in 2002). As a result, the group of children age 6-12, which changed little in sheer numbers, became a larger

[4] For example, Sara Collins et al. 2004. Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help. *The Commonwealth Fund.* Can be retrieved at www.cmwf.org

portion of uninsured children, increasing from almost 38% to 44% (Figure 1-5). **Over 75% of uninsured children are school age,** about 57,000 in 2002 (Table 1-1.) Furthermore, although uninsurance rates for all children's age groups have declined progressively since 1998, **the likelihood of being uninsured increases as children reach school age** (Figure 1-6). This is consistent with cut-off points for public programs that focus on coverage for infants. In 2002, the uninsurance rate for infants under age 6 was 3.3%, while rates for school age children moved closer to 5%.

Family Income:

Family income remains a persistent underlying factor in the uninsurance rate and for the source of insurance for those who are insured. About 58% of the uninsured are members of families with incomes up to 200% of federal poverty[5] (Figure 1-7) although this group represents less than 30% of Washington's under age 65 population. Families with incomes over 400% of federal poverty represent 44% of the population under age 65 but less than 15% of the uninsured. This disparity has remained fairly consistent in spite of the potential availability of public programs for adults with family incomes up to 200% of federal poverty and for children in families with incomes up to 250% of federal poverty. In both 2000 and 2002 more than 75% of the uninsured were in families earning less than 300% of federal poverty ($54,300 for a family of four in 2002).

The likelihood of being uninsured has increased at almost all income levels, an indication of the impact of Washington's economic downturn in recent years, the corresponding increase in unemployment, and changes made in the funding of health care to help address a fiscal gap of $2.7 billion in a budget of $23 billion. While the likelihood of being uninsured clearly declines with income, **upper income families (over 400% of federal poverty) and lower-middle income families (between 200% and 300% of federal poverty) are the fastest growing segments of the population without health insurance** (Figure 1-8). Lower-middle income families are the most likely to be feeling stressed given a 30% increase in their rate of uninsurance, 5 times the rate of increase in the poorest families (up to 200% of federal poverty) who are traditionally supported by public programs. Although changes in public programs have resulted in a loss of coverage for some families, public programs have clearly dampened the effect of the economic downturn on the lowest income families. But, many lower-middle income families are virtually one "pink slip" away from being uninsured.

The priority Washington has placed on ensuring that children have access to health insurance is clearly evident in the variation in source of coverage by income. Close to 70% of children in low income families, up to 200% of federal poverty, have consistently been covered through public programs (Figure 1-9). For children in higher income families public programs play a minor role and employer based insurance covers about 80% of these children. With Medicaid, SCHIP and Basic Health programs available as potential coverage options for children in families up to 250% of federal poverty, it is somewhat surprising that in 2002 and even in 2000, children in low income families were actually more likely to be uninsured than all children. In 2002, low income children had an uninsurance rate of 6.2% (about 40,000 individuals) compared with higher income children whose rate of uninsurance was 3.4% (about 33,000 individuals) (Figure 1-9 and Figure 1-10).

[5] Federal poverty guidelines are a federal measure of poverty issued each year in the *Federal Register* by the **Department of Health and Human Services** (HHS). In 2002, the poverty level was defined as an income of $8,860 for the 1st member of a family plus $3,080 for each additional family member (i.e., for a family of four, the federal poverty level was $18,100.) A description of federal poverty measures is available at: http://aspe.hhs.gov/poverty/01poverty.htm. Specific federal poverty guidelines from 1982 to 2004 are available at: http://aspe.hhs.gov/poverty/figures-fed-reg.shtml.

Figure 1-10 shows that **if all children potentially eligible for public programs were enrolled, about 68% of uninsured children would be insured** (over 49,000 individuals). This is important because many studies[6] show that lack of insurance coverage negatively affects access to care among low income children. Uninsured but Medicaid eligible children are twice as likely as those enrolled in Medicaid to have an unmet medical need and to have not seen a doctor. To close the gap in access to health care for children, **ensuring that public programs cover all potentially eligible children would leave only 1.5% of all children uninsured**.

Furthermore, if there were no funding or enrollment limitations on public programs, we estimate that about 243,000 more adults would be potentially eligible for coverage; over 60% of whom could join the Basic Health program. Adding children to the mix, **about 58% of the uninsured under age 65 could potentially be covered under current public programs** (292,000 individuals).

Gender:

Among children (under age 19) and adults, the likelihood of being uninsured is greater for males than females, however, of all groups male adults are the most likely to be uninsured. A little over 13% of male adults are uninsured whereas just over 9% of female adults are uninsured (Figure 1-11). This discrepancy is further evident in the gender distribution of the under age 65 uninsured population. Public programs have been so effective in reaching women and children in particular that **male adults now make up 50% of the under age 65 uninsured population** (just over 250,000 individuals). However, likely as a result of public program changes, the number of uninsured female adults actually increased at a faster rate than males, almost 20% for females compared with just over 18% for males.

Health Status:

Individuals who report that they are in excellent or very good health are about half as likely to be uninsured as individuals who are less healthy (Figure 1-13). This supports the growing body of literature suggesting that although insurance doesn't guarantee access to health care it remains an important vehicle. When health status is aligned with source of insurance it appears that healthier pools of individuals tend to be covered by employer-based and individual markets products (Figure 1-14) and less healthy pools are either covered by public programs or are uninsured.

Family Composition:

Given public programs emphasis on covering children and their parents, it's not surprising to find that young adults age 19 to 34 without dependent children[7] make up a large portion of the uninsured (approximately 25% of all uninsured; approximately 30% of uninsured adults). The public program targeted to low income adults, Basic Health, has been unavailable to many of them as a result of limits on enrollment driven by public program funding challenges. Approximately **half the uninsured under age 65 are adults without dependent children** (around 250,000 individuals) (Figure 1-15).

At most levels of family income, adults without dependent children make up the largest portion of the uninsured, but this is particularly evident in families with incomes over 300% of poverty (Figure 1-16). In the highest income families, (those over 400% of federal poverty) close to two-thirds of the uninsured are adults without dependent children.

[6] Dubay, L. et al. 2001. Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children. *Urban Institute*.

[7] Legal guardians of children, including grandparents, are recognized as parents for analyses of the relationship between children, their parents and their uninsurance status.

From our initial SPG research we found that a **key factor in predicting the insurance status of children is the insurance status of their parents**; only 2% of children with an insured parent were uninsured. In 2000 and in 2002, **over 60% of uninsured children in Washington had uninsured parents**. As discussions continue to focus on options for covering children, understanding patterns of uninsurance in families with children is clearly a critical issue. While we have not been able to examine these patterns in our recent work, we plan to conduct more targeted analysis of families with children once 2004 WSPS data are available.

In these families we are also interested in further understanding the relationship between family coverage and use of health services. National studies [8] find that parents' use of health services strongly influences their children's use of health services**.** Parents who are insured are more familiar with systems, and especially when covered by the same insurance as their children, they are more effective advocates for their family's care. When parents are uninsured they are more likely than insured parents to delay or forgo getting care for themselves and their children. Although changes in public program eligibility over the past 15 years have generally enhanced access to coverage, they have created a situation in many low-income families where not all members are eligible and where coverage differs for different age groups. While ensuring coverage for children continues to be an accepted public priority, **neglecting to insure their parents may have the unintended effect of reducing the impact of insurance for children**.

Employment Status:

In 2000, close to 75% of the uninsured (341,000 individuals) were members of families in which at least one adult was working (Figure 1-17). In 2002, that pattern continues, in spite of Washington's economic challenge and steady ranking for unemployment among the top three states. **Close to 70% of the uninsured under age 65 (348,000 individuals) are found in families with one or more workers** (Figure 1-18).

In a nation in which health insurance is typically financed by employers (see Section 2), the importance of having workers in a family is striking – to gain access to coverage and to support the financial ability to afford coverage. In 2000, before we felt the impact of the recession, the uninsurance rate among families with no workers was close to five times the rate in families with two or more workers. Although that gap closed in 2002, the uninsurance rate in families with no workers remained at least double the rate in families with one worker and more than three times the rate in families with two or more workers (Figure 1-19). This is consistent with studies that connect rising unemployment rates with related loss of health insurance. For example, Lambrew[9] determined that the rate of uninsurance among unemployed adults is nearly three times the rate in the general population.

Race/Ethnicity:

As is shown in national studies, Washington's uninsured population has historically been predominantly White. Results from each WSPS since the inception of the survey, show that around

[8] Sample studies that confirm this picture on a national level include: Davidoff, A. et al. 2001. Patterns of Child-Parent Insurance Coverage: Implications for Coverage Expansions. *Urban Institute*. Assessing the New Federalism, Series B, No. B-39, November 2001; Hanson, Karla. 2001. Patterns of Insurance Coverage Within Families with Children. *Health Affairs*, 20(1):240-246; Dubay, L. et al. 2001. Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children. *Urban Institute;* Kaiser Commission on Medicaid and the Uninsured. 2002. Enrolling Uninsured Low-Income Children in Medicaid and SCHIP. Fact Sheet #2177-03.

[9] Lambrew, Jeanne. 2001. How the Slowing U.S. Economy Threatens Employer-Based Health Insurance, *The Commonwealth Fund.*

73% of the uninsured are White, (close to 372,000 individuals in the 2002 survey) (Figure 1-20). Hispanics account for about 14% of the uninsured and other groups, Black, American Indian/Alaskan Native and Asian/Native Hawaiian are between 3 and 5% each.

The likelihood of being uninsured is highest for Hispanics and American Indian/Alaskan Natives and these groups have historically remained disproportionately uninsured (Figure 1-21). While the percent of Whites that are uninsured has remained steady at around 8-9%, rates among the other groups have fluctuated in recent years. This variation reflects standard issues in the collection of race and ethnicity data that affect the reliability and comparability of the data over time: how people report and how the data are coded[10]. But it is important to not get sidetracked by these data issues. Regardless of the data noise, the fundamental message is the consistent insurance disparity for Hispanics and American Indian/Alaskan Natives.

Immigration Status:

Although non-citizens are nearly twice as likely to be uninsured as citizens, in sheer numbers citizens have historically made up the bulk of the uninsured. As might be expected, some survey respondents are reluctant to divulge their immigration status. In 2002, they represented less than half a percent of the uninsured and therefore do not impact the message. In 2002, citizens made up over 94% of the uninsured (approximately 472,000 individuals, Figure 1-22) while they comprised about 96% of the total population under age 65. Non-citizens made up almost 6% of the uninsured (28,000 individuals) and almost 4% of the total population under age 65.

Education:

National studies have shown that the presence of a college degree is positively related to income and is associated with employment in certain sectors and types of jobs that are more likely than others to include a health insurance benefit[11]. The rate of uninsurance for adults without a high school degree is about 4.5 times as high as the rate with a college degree and nearly three times as high as the rate with some college education (Figure 1-24). Our initial SPG research indicated that this discrepancy is likely not as striking as it seems. When income and other factors were controlled for, rates of insurance improved less dramatically with increasing education, and the adjusted rate for individuals without a high school degree was only twice as high as the rate with a college degree. These differences are likely related to economic opportunities more available with higher education levels.

Of interest in Washington as a potentially insurable group is the sub group of students who attend university or college and are uninsured. Depending on the data source we estimate between 33,000 and 47,000 uninsured students at 4-year universities and community and technical colleges[12]. Anecdotal comments suggested that students who were uninsured had access to an on-site clinic for needed services, were typically healthy and simply could not afford health insurance.

---

[10] In asking survey respondents to identify their race, WSPS, like the Current Population Survey (CPS), offers respondents the option of choosing one or more races, which are then recoded to identify a primary race. Hispanic origin is reported separately, reflecting an ethnic heritage rather than a racial group. An individual can therefore be both White and Hispanic, Asian and Hispanic, Native American and Hispanic. In our analysis of race/ethnicity the Hispanic category includes all individuals that identified their ethnicity as Hispanic, regardless of their chosen race.

[11] Gabel, Jon. 1999. Job-Based Health Insurance, 1977–1998: The Accidental System Under Scrutiny. *Health Affairs* 18(6):62–74.

[12] From projected 2002 student figures we estimated that there might be about 14,000 4-year college students and 33,000 community and technical college students uninsured at some time in 2002. Based on self-reported student status available in WSPS 2002 we estimated that just over 10,000 4-year college students and just over 22,000 community and technical college students were uninsured.

Geographic Location / Region:
WSPS divides Washington state into eight geographic regions. Regions (underlined) and counties within each are as follows:

Mostly Urban: • Clark: Clark • Other Puget Metro: Kitsap, Pierce, Snohomish, Thurston • King: King
Mixture of Urban and Rural: • Spokane: Spokane
Mostly Rural: • West Balance: Clallam, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania, Wahkiakum • Yakima-Tri-Cities: Benton, Walla Walla, Yakima • North Puget Sound: Island, San Juan, Skagit, Whatcom • East Balance: Adams, Asotin, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Stevens, Whitman.

In general, as in 2000, rates of uninsurance are lower in the more urban regions of the state; the lowest uninsured rates occuring in Clark County (7.1%), King County (7.4%) and the Other Puget Metro region of Thurston, Pierce, Kitsap and Snohomish Counties (8.7%) (Figure 1-25). The "West Balance" region, which represents most rural Western Washington counties, has the highest uninsured rate at 14.3% in 2002. Uninsurance rates are also relatively high in Eastern Washington, especially in the most rural counties (excluding the more metropolitan areas of the Spokane and the Yakima-Tri Cities regions). These discrepancies are largely due to economic and demographic factors that result in typically higher rates of uninsurance in rural than urban areas. However, from 2000 to 2002 many parts of the Puget Sound area saw dramatic increases in the rates of uninsurance; the West Balance region with a 49% increase and the Other Puget Metro region with a 33% increase.

The dominance of employment as a source of coverage continued in all regions (Figure 1-26), with the higher rates of employer coverage in the more urban regions of Clark (75%), King (72%), and Other Puget Metro (69%).

As expected, public coverage continued to play a more prominent role in the more rural regions where seasonal and temporary employment are often concentrated. Public programs covered just over 30% of the under age 65 population in the East Balance region, and just under 29% in the North Puget Sound and Spokane regions. Rates of uninsurance in 2002 were dampened in some regions by large increases in public coverage; the North Puget Sound (51%) and King County (33%) regions in particular; and by increases in employer-based coverage in the Tri-Cities region (23%).

Reasons for Uninsurance:
The reasons people typically give for not having health insurance (in national as well as in our state household survey) are:

- **Insurance is unaffordable**. Overwhelmingly this is the reason given for not having health insurance. Research conducted during the initial phase of our grant showed that in Washington, many families cannot afford to buy private coverage unless their incomes are above 250% of federal poverty (see http://www.ofm.wa.gov/accesshealth/research/33affordability.pdf).

- **Employer doesn't offer**. In some cases the employer offers coverage but the person is ineligible (e.g., may be part-time, seasonal, hasn't worked for the company long enough).
- **Unemployed or in-between jobs**.
- Another family member has **insurance** but it **doesn't cover the whole family**.
- **Can't get insurance or were refused**, usually because of poor health or age. For example, applicants in Washington's individual market must pass a health screen. Many of those who do not pass and are referred to the state's high-risk pool do not follow-through because they consider it to be too costly (even for those with some subsidy assistance).
- **Don't think it's needed** because they are healthy. Young adults are most likely to give this reason although overall it is rarely cited as the main reason for not having insurance

Other contributors to peoples' uninsured status include:

- **Ineligibility for public programs** such as Medicaid (primarily focused on children) or the state-only, subsidized Basic Health program for working adults under 200% of federal poverty (enrollment slots limited).
- **Other perceived or real barriers** such as knowledge about insurance options and how to access them; newly implemented administrative and cost-sharing changes that make continuous enrollment in public programs more difficult; an historically strong safety net that could be substituted for insurance (described in Section 4); and for some immigrant groups, the whole concept of insurance is simply foreign and senseless.

B. Technical Assistance:

While the SPG has had the effect of shining a spotlight on the WSPS as the most comprehensive source of data on Washington's uninsured individuals and families, this has been a somewhat mixed blessing. The data support sub-state analyses that provide valuable insights to health care issues at a local level with a degree of credibility and depth that cannot be matched by national surveys[13]. The increased interest in WSPS has motivated improvements in the data collection and coding processes, including: adjusting for Medicaid undercounting (described below); adding a question to verify lack of insurance coverage; honing the capture of Medicare recipient information; and, recoding variables that describe labor force participation and employment characteristics. It has also established the SPG as a "clearinghouse" for questions and data on Washington's uninsured population. Examples of the types of questions presented to SPG staff in support of understanding data on the uninsured are included in Appendix 1.

At the same time, we continue to struggle with the timeliness of available data and the need to make the right information available to interested stakeholders, in a usable way, quickly. Existing data by their very nature tell yesterday's story. In the context of a changing (and declining) health system we can run the risk of missing the nuances important for today's discussions or worse, being irrelevant to the discussion. In an effort to speed up access to more broadly available information, we participated in the Multi-State Integrated Database (MSID) championed by Arkansas. Thus far our efforts have been successful in defining the set of WSPS variables most pertinent to analyses of the uninsured (Figure 1-27) and these data are being loaded into a local cube for Washington. With

[13] Details on the value of local data to Washington were discussed with SHADAC in answer to a series of questions including: What type of local nuances did your state-level household survey identify? What questions from policy makers or the public were you able to answer using your state data that you would otherwise have been unable to answer? What did any state or local policy makers do with this information that they could not have done with data from the CPS, NSAF, NHIS or BRFSS?

the success of the SPG Continuation Grant application we hope to complete the development of the local cube, add 2004 WSPS data, and establish a sustainable "home" for the project into the future.

And finally, we struggle with the focus of media, advocates, policymakers, and others on the question, "Which number of uninsured is right?" as results of national and local surveys provide confusingly different percentages of Washington's uninsured. When the story, if not the numbers, is consistent across all surveys it is disappointing to see such energy directed towards getting to "the right number" and explaining why the numbers are different. Perhaps the dilemma is best explained this way: All estimates are wrong, some are useful, most tell the same story.

Medicaid Undercounting.
When findings from our preliminary 2002 WSPS analysis were seriously questioned by legislative staff, we collaborated with the WSPS statisticians to understand why rates of children's coverage by public programs looked lower than expected from historical administrative data. The interpretation was that we must have seriously overstated the rate of uninsurance in the state by undercounting the numbers of individuals enrolled in Medicaid and Medicare. A considerable body of national literature describes underreporting as a problem for other surveys including the Current Population Survey, Survey of Income and Program Participation, Medical Expenditure Panel Survey and the Community Tracking Survey, the undercount ranging from 7 to 50%[14]. The undercount in the 2000 WSPS was estimated to be around 25% and appeared to have been growing over time.

WSPS statisticians developed a methodology to adjust for the undercount; we assisted in testing the results and we called upon SHADAC staff to help keep us honest. A brief description of the adjustment methodology is included in the side box. SHADAC's peer review is included in Appendix 2. For children, the impact of the correction was huge. Their rate of uninsurance dropped from 8.5% in the preliminary (questionable) analysis to 4.5% after controlling for the Medicaid undercount, a rate that passed the straight face test, given its alignment with administrative data.

Medicaid Undercount Correction Methodology

Step 1: Imputations were made to correct responses where insurance information was missing but the individual had a high probability of being on Medicaid based on their responses to other WSPS questions (e.g., participation in TANF, Supplemental Security Income and children whose parents were on Medicaid.)

Step 2: Post-stratification weighting was changed to incorporate Medicaid administrative counts in addition to Washington's Census and population forecasts, so that adjusted weights better reflected characteristics of Washington's total population.

A technical description of the methodology is available at http://www.ofm.wa.gov/research/briefs/brief020.pdf.

Note: In general, figures cited are point estimates and do not reflect confidence interval ranges. Caution is encouraged in interpreting percentages that, in particular, are small and/or close together.

[14] Many researchers have noted that general population surveys of health insurance coverage appear to undercount the number of individuals enrolled in Medicaid programs. Swartz, K. and J. Purcell (1989). "Letter: Counting uninsured Americans." *Health Affairs* 8(4): 193-197.

Figure ES-1: A HISTORY OF WASHINGTON'S STATE PLANNING GRANT ON ACCESS TO HEALTH INSURANCE

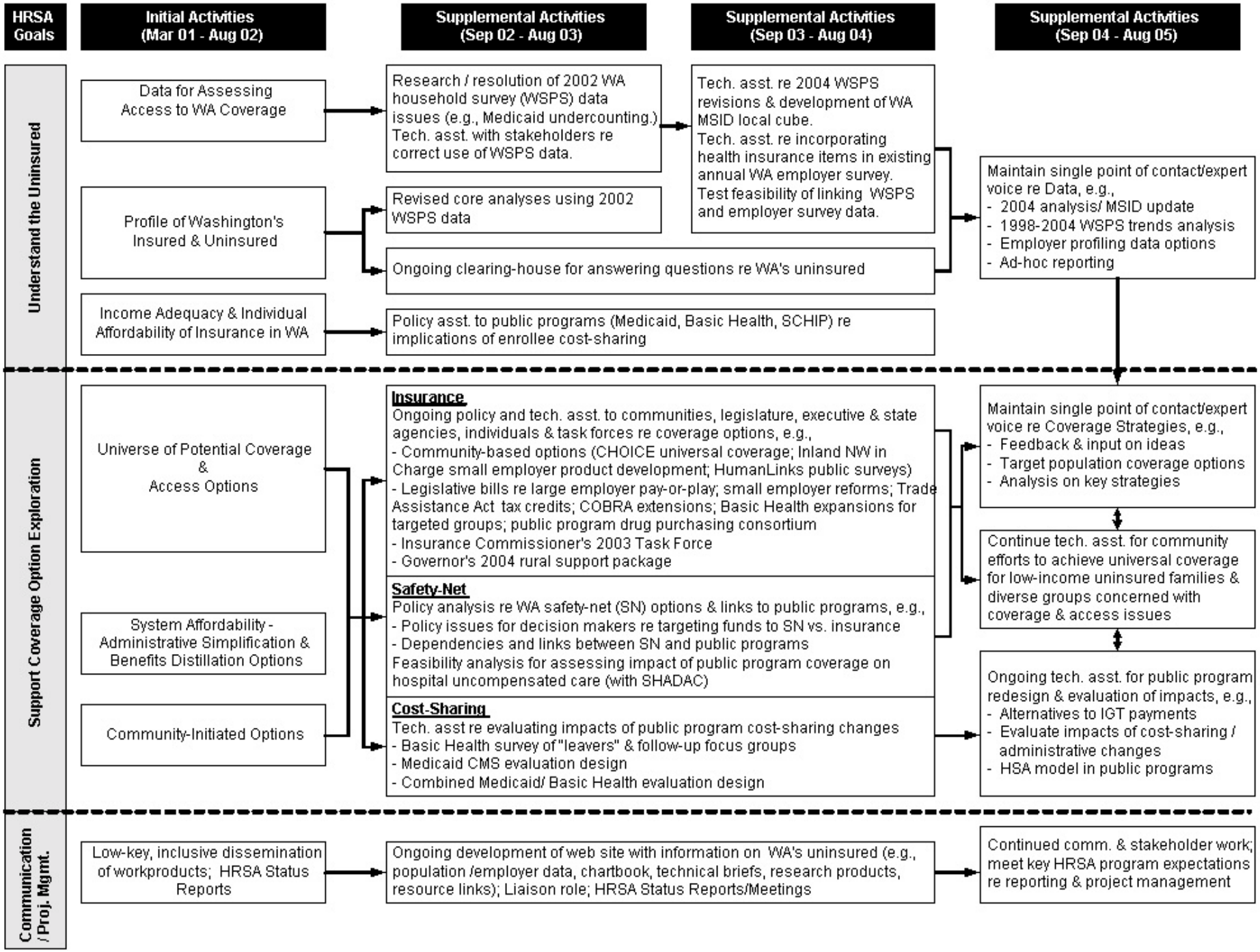
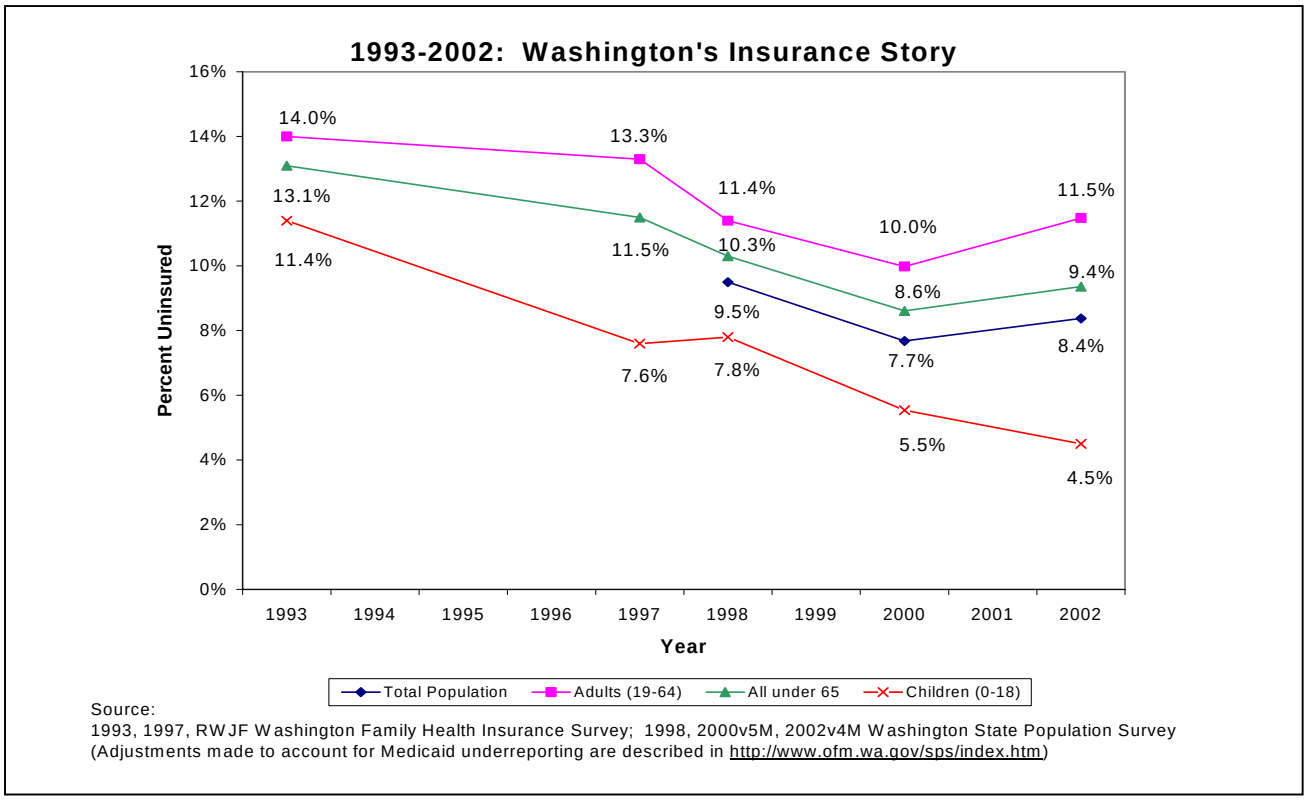
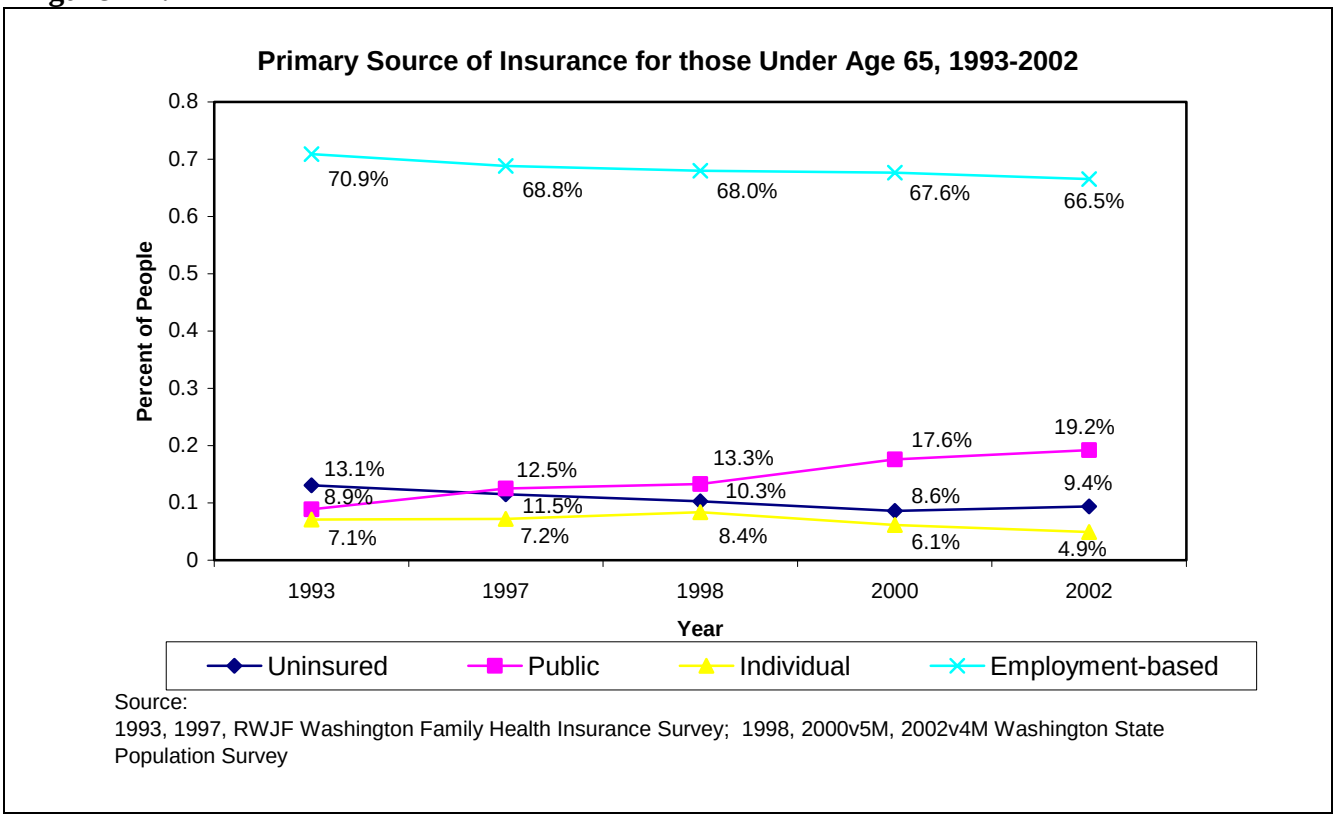


Figure 1-1.



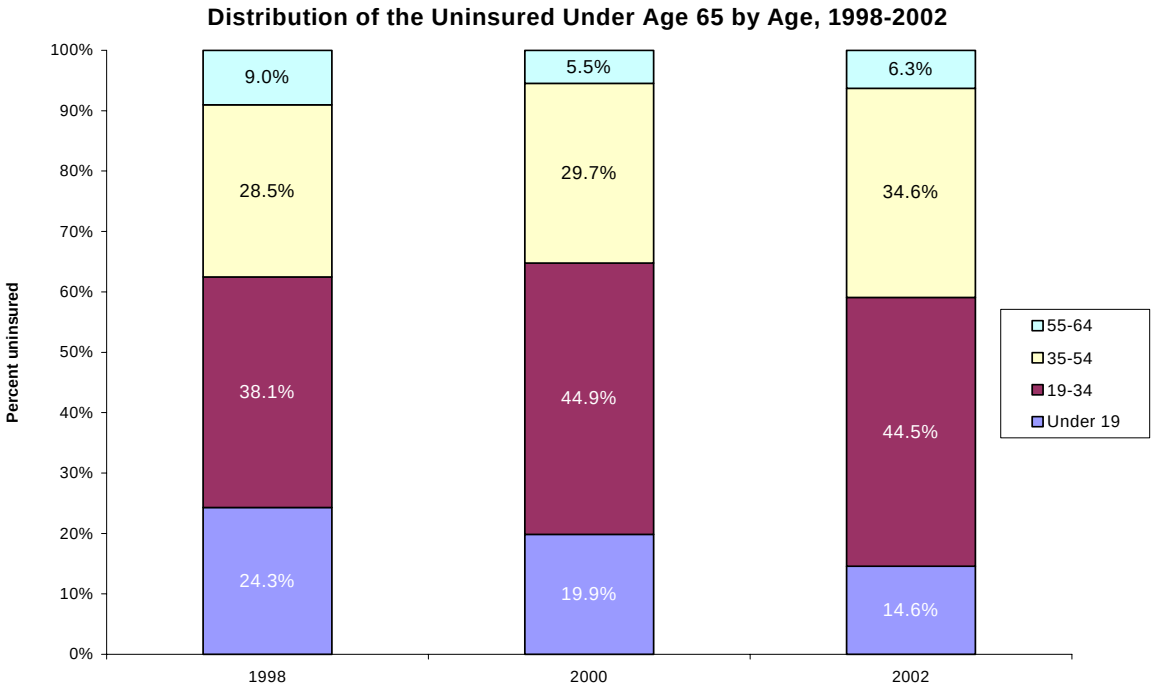
Source:
1993, 1997, RWJF Washington Family Health Insurance Survey; 1998, 2000v5M, 2002v4M Washington State Population Survey
(Adjustments made to account for Medicaid underreporting are described in http://www.ofm.wa.gov/sps/index.htm)

Figure 1-2.



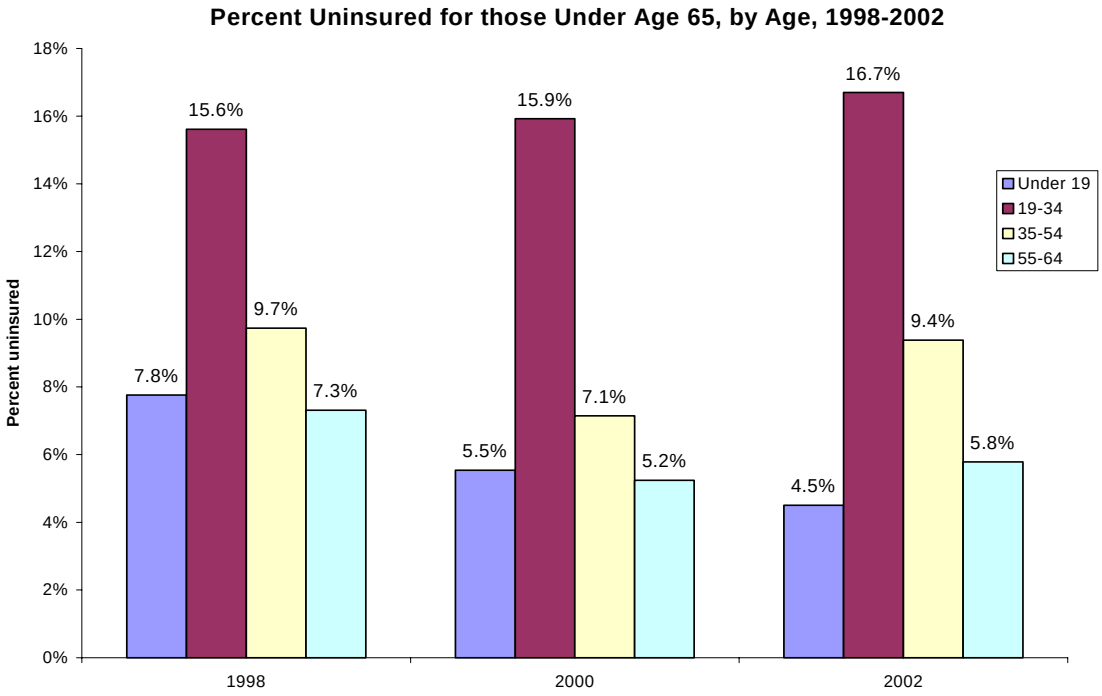
Source:
1993, 1997, RWJF Washington Family Health Insurance Survey; 1998, 2000v5M, 2002v4M Washington State Population Survey

Figure 1-3.



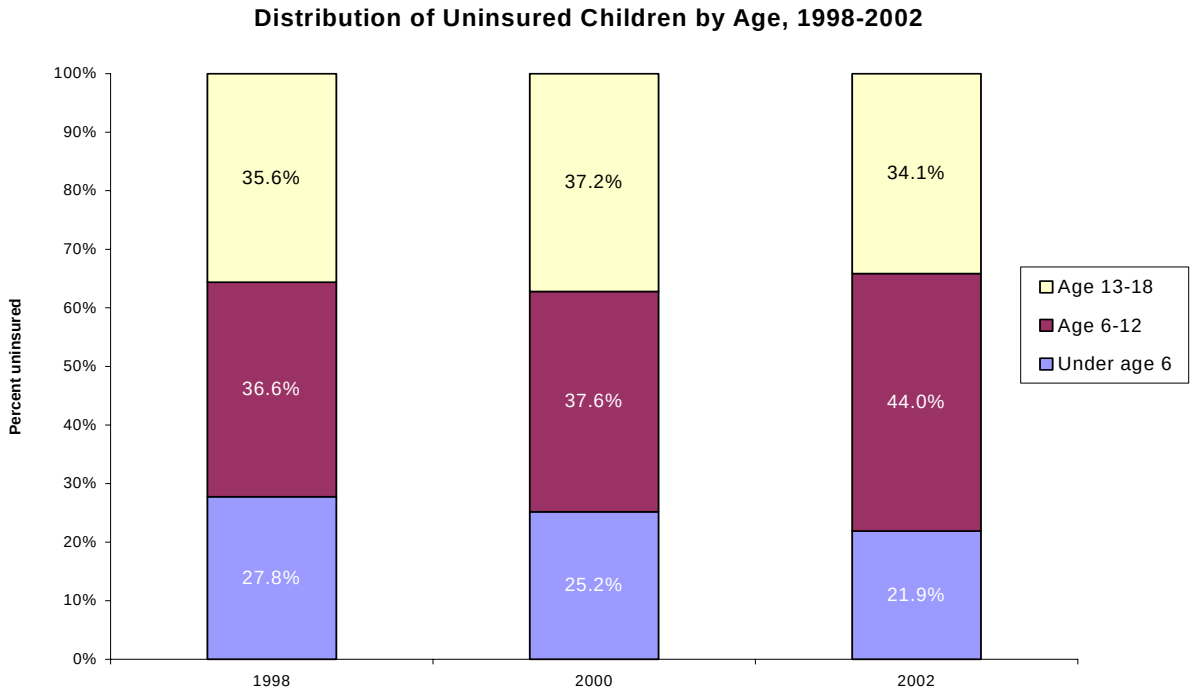
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-4.



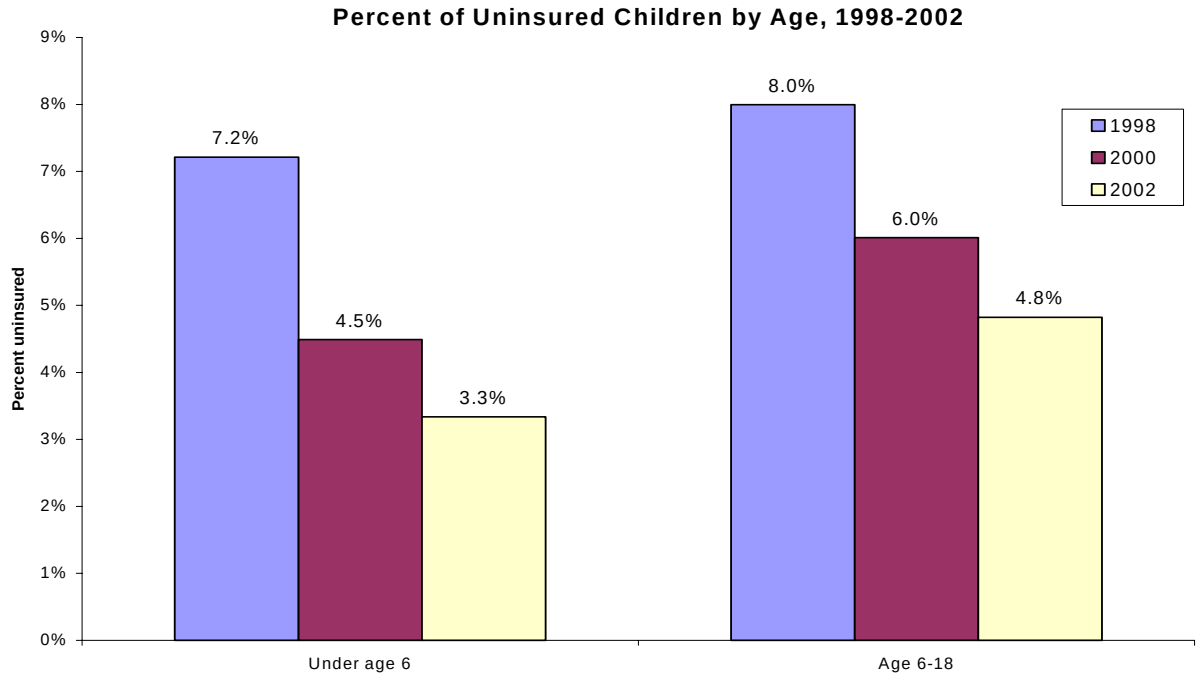
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-5.



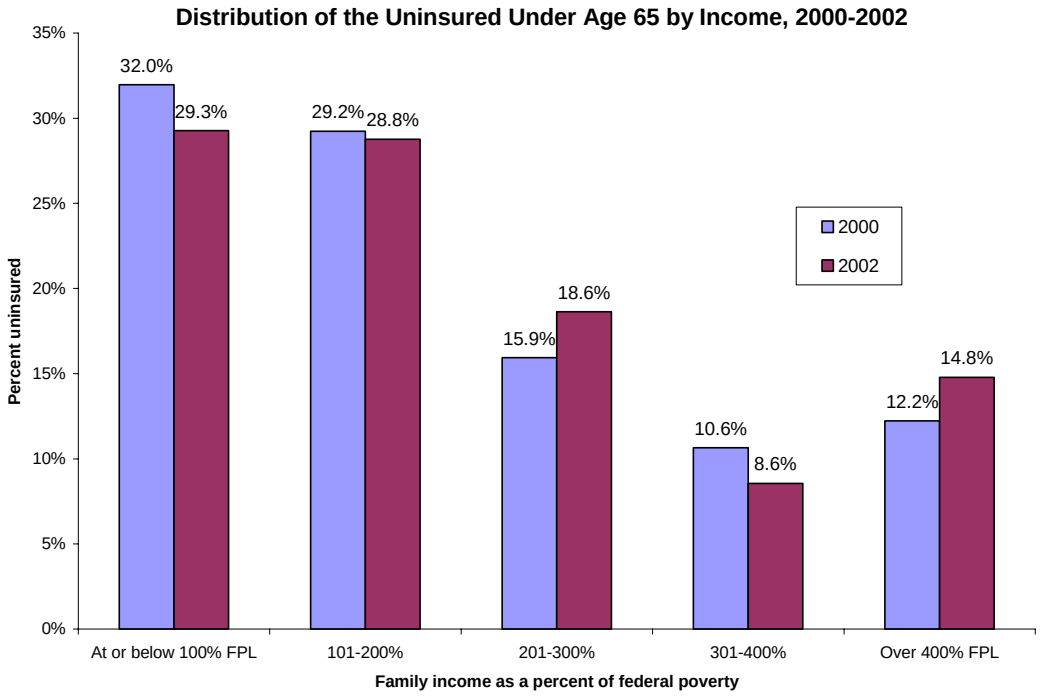
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-6.



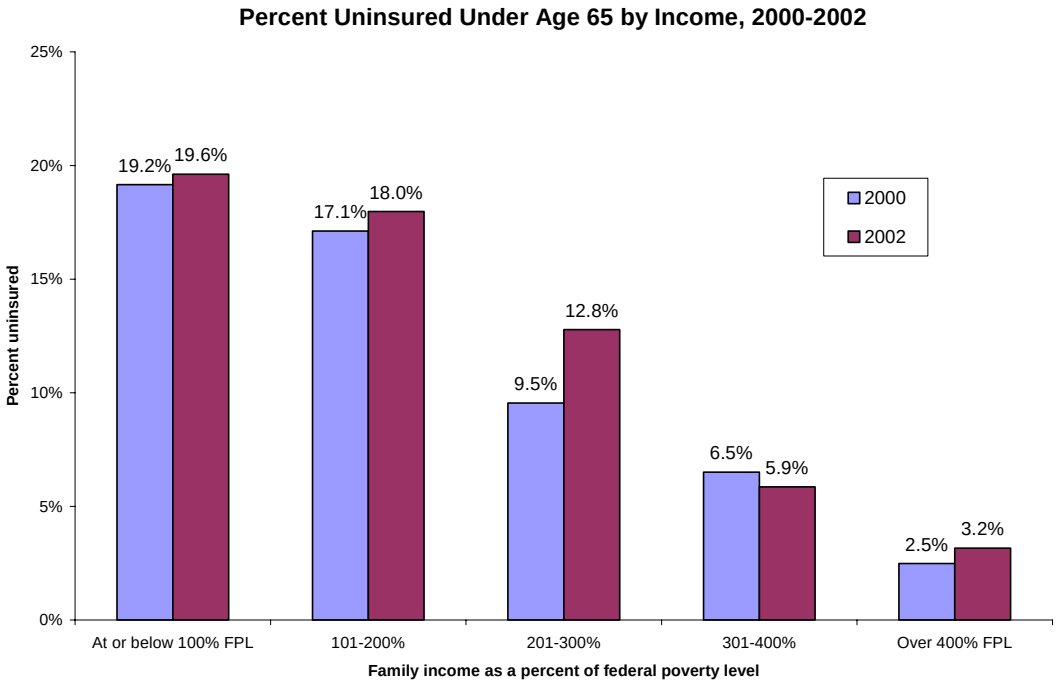
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-7.



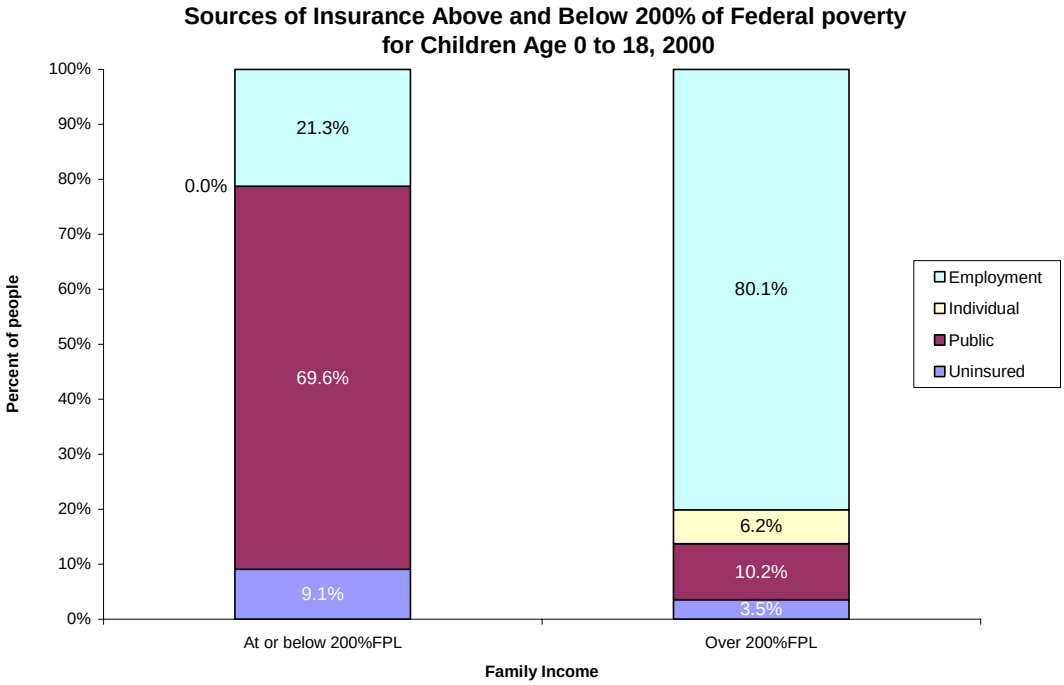
Source: Washington State Population Survey 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-8.

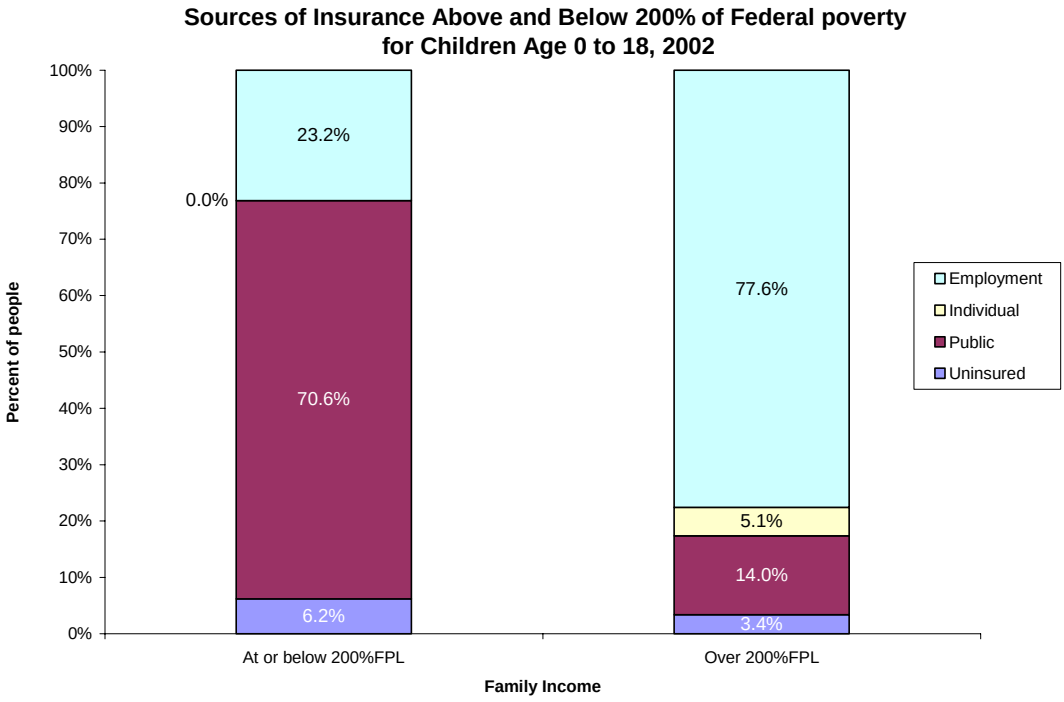


Source: Washington State Population Survey 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-9.



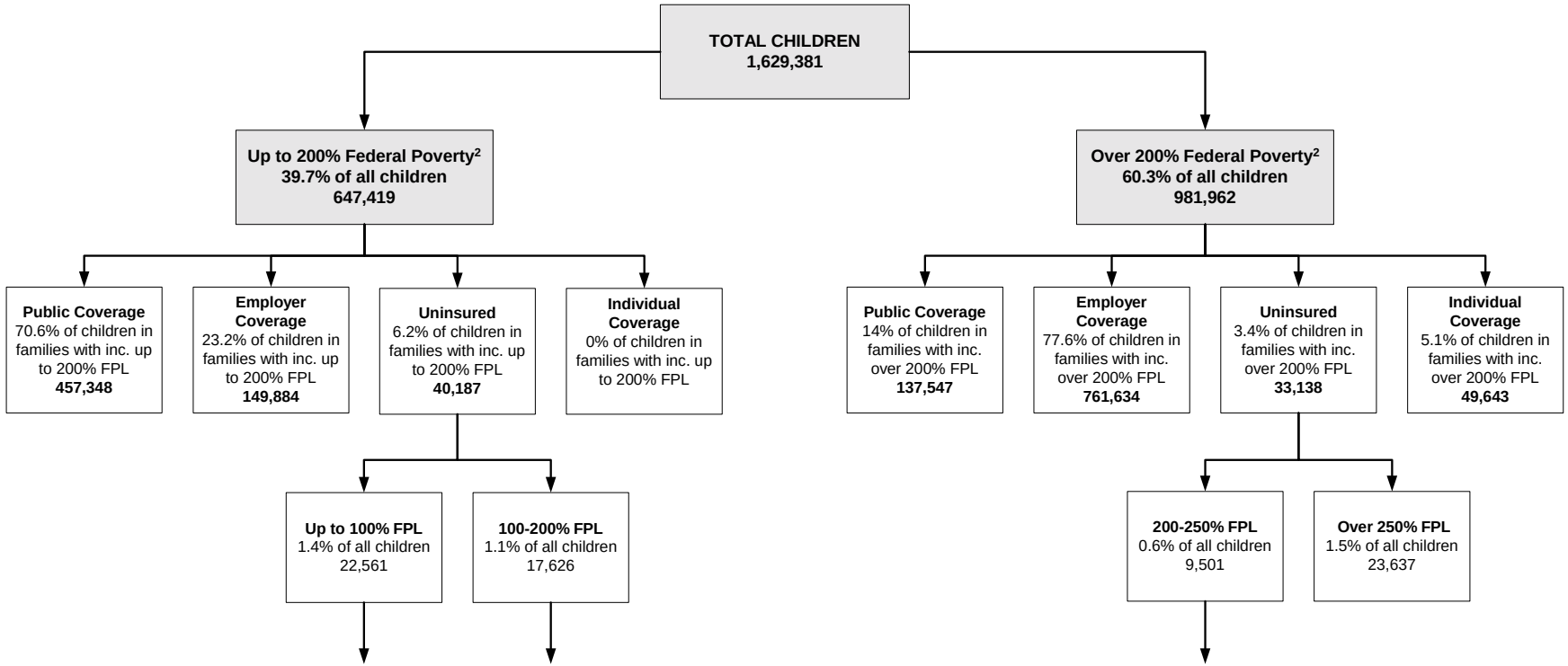
Source: Washington State Population Survey 2000v5M
(Adjustments made to account for Medicaid underreporting are described in http://www.ofm.wa.gov/sps/index.htm)



Source: Washington State Population Survey 2002v4M
(Adjustments made to account for Medicaid underreporting are described in http://www.ofm.wa.gov/sps/index.htm)

Figure 1-10.

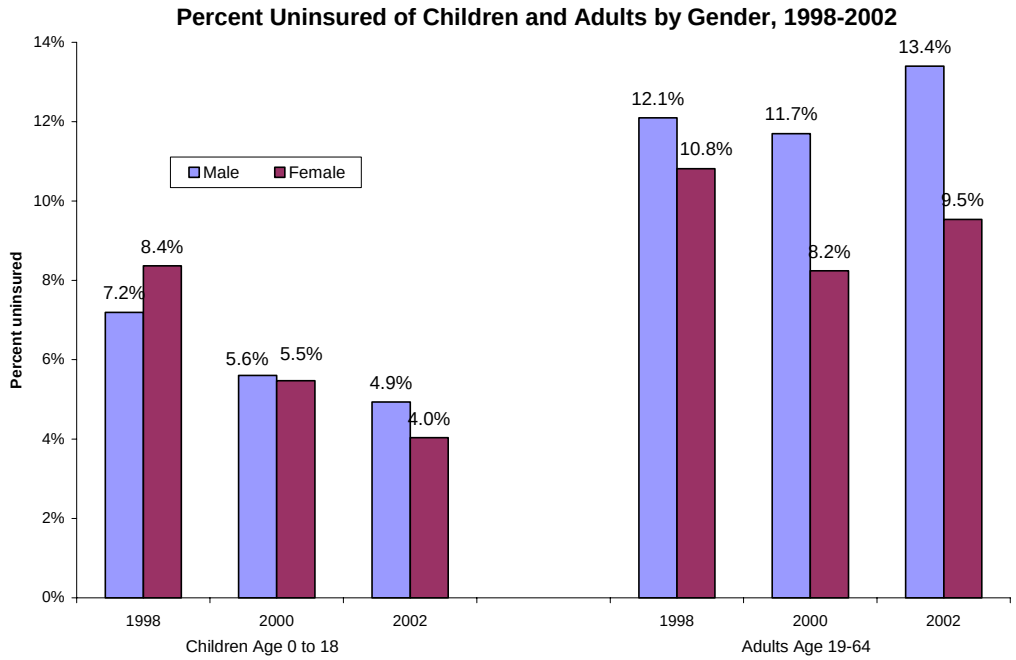
WASHINGTON STATE PLANNING GRANT ON ACCESS TO HEALTH INSURANCE
2002 Children Age 0-18 Years [1]



67.8% of all uninsured children are potentially eligible for public coverage through the current Medicaid, SCHIP, and Basic Health programs.

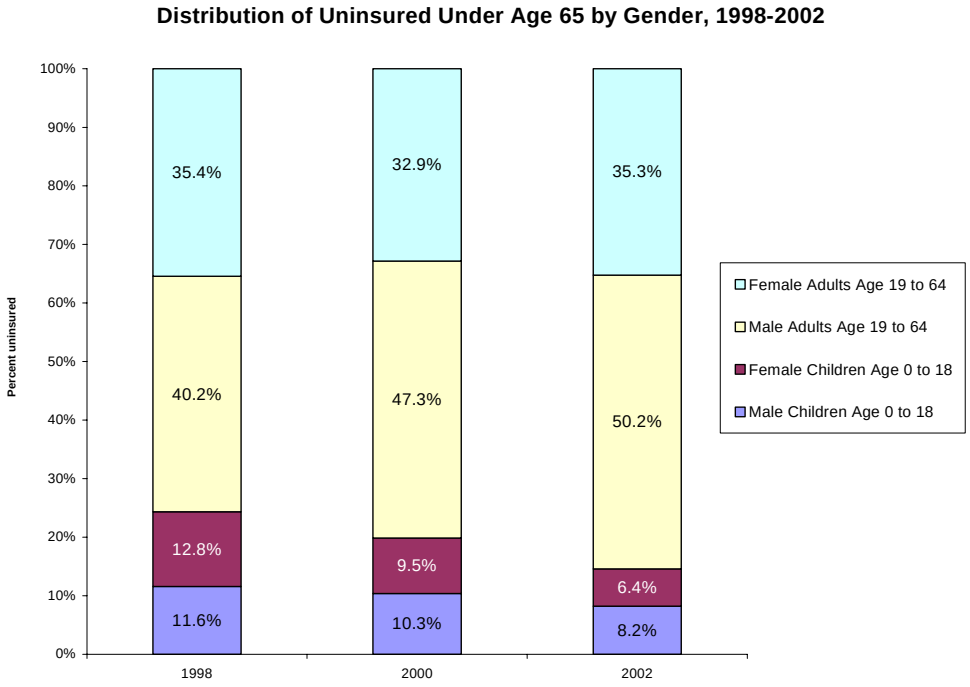
[1] Source: 2002v4M Washington State Population Survey
[2] Poverty level for a family of four in 2002 was defined as $18,100.
For more information see the Department of Health and Human Services website http://aspe.hhs.gov/poverty/figures-fed-reg.shtml

Figure 1-11



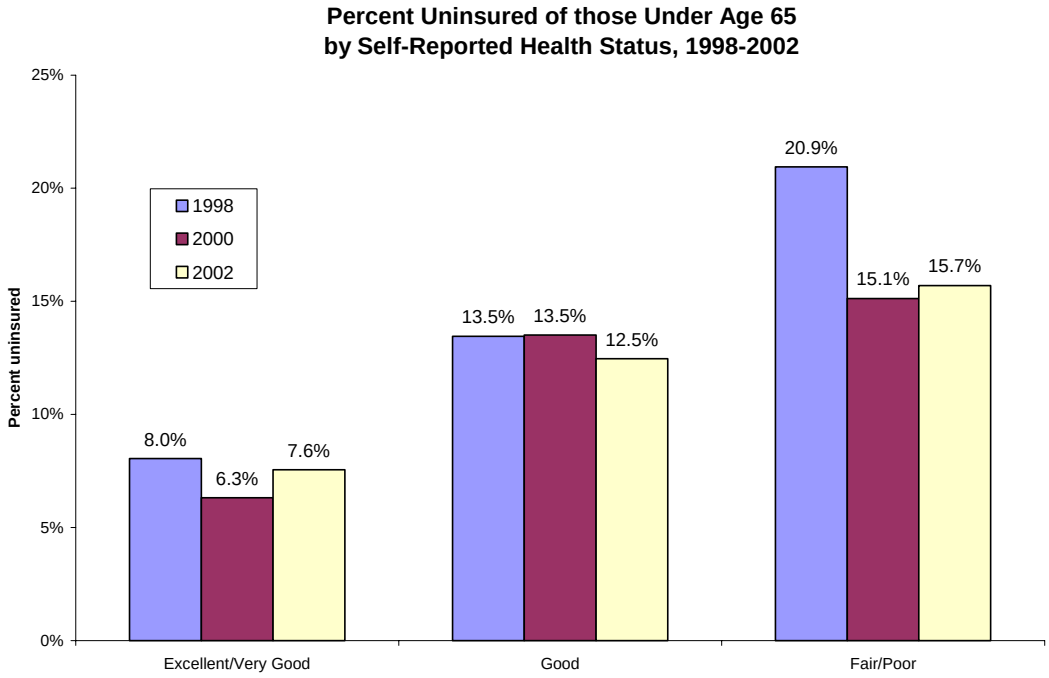
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-12



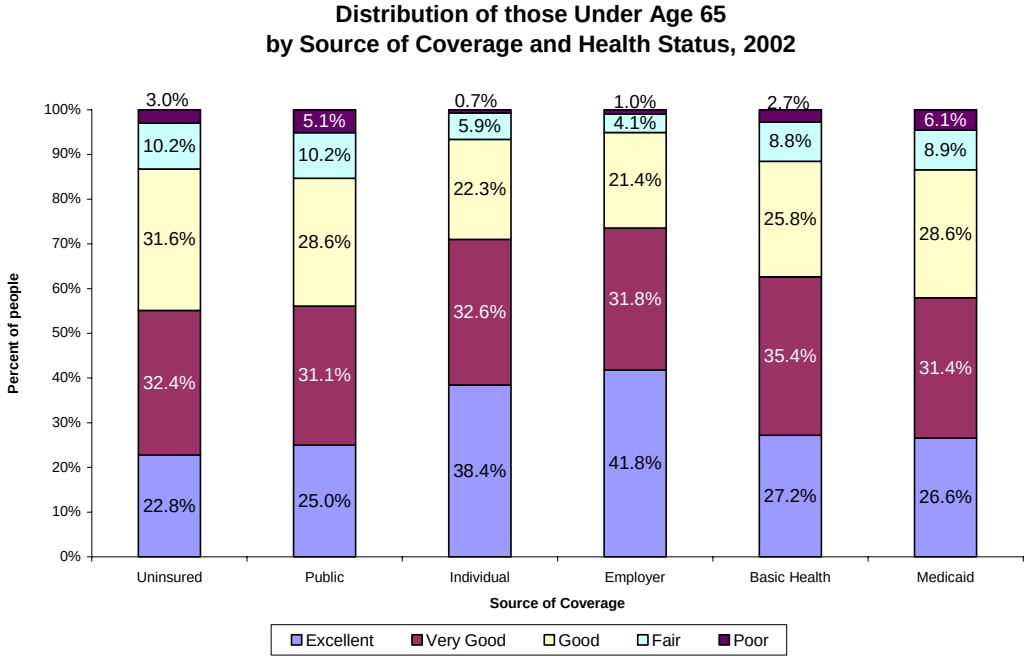
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-13



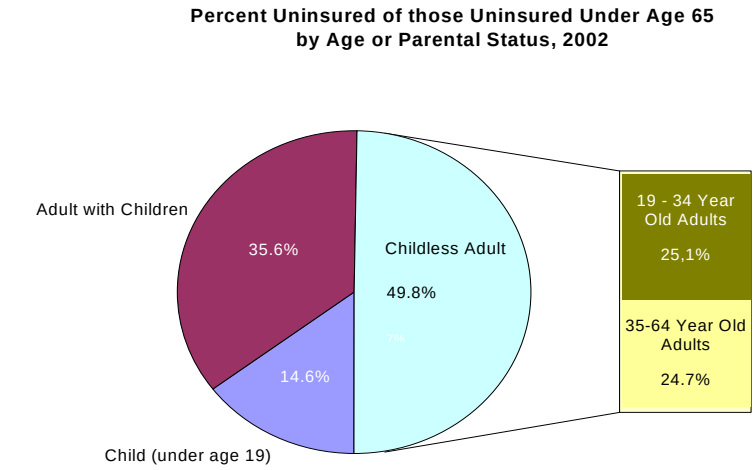
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-14



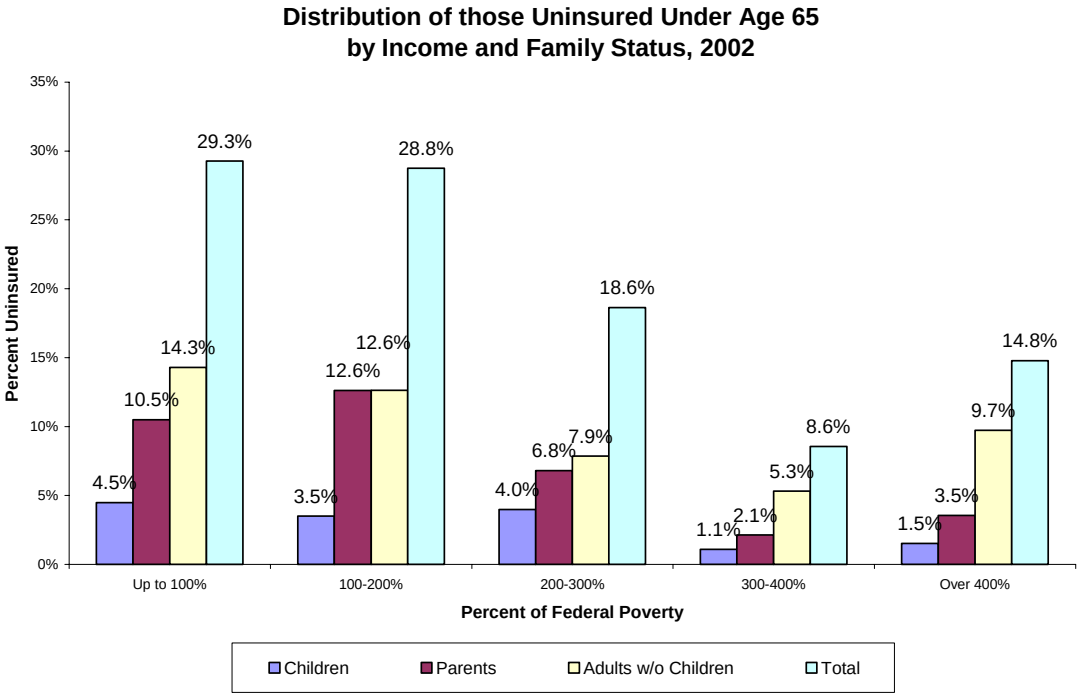
Basic Health and Medicaid are shown separately and also included as subsets of Public coverage.
Source: Washington State Population Survey 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-15



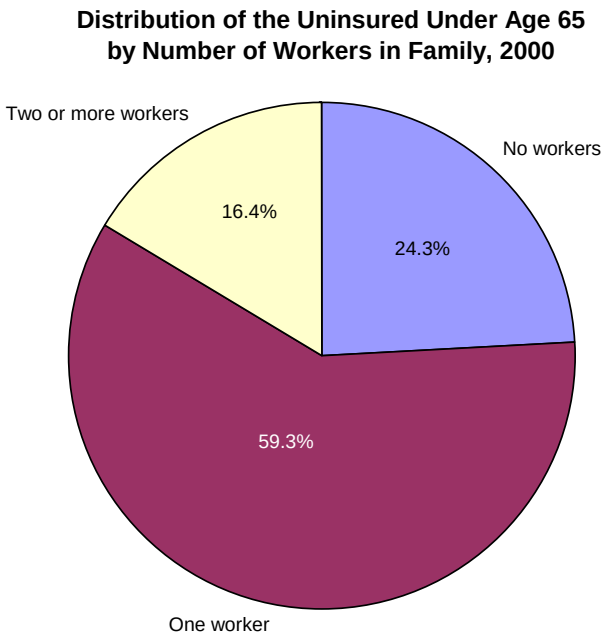
Source: Washington State Population Survey 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-16



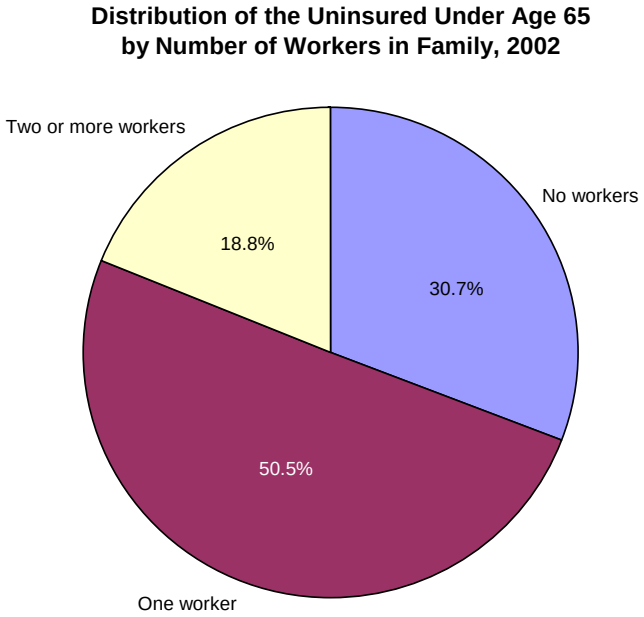
Source: Washington State Population Survey 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-17



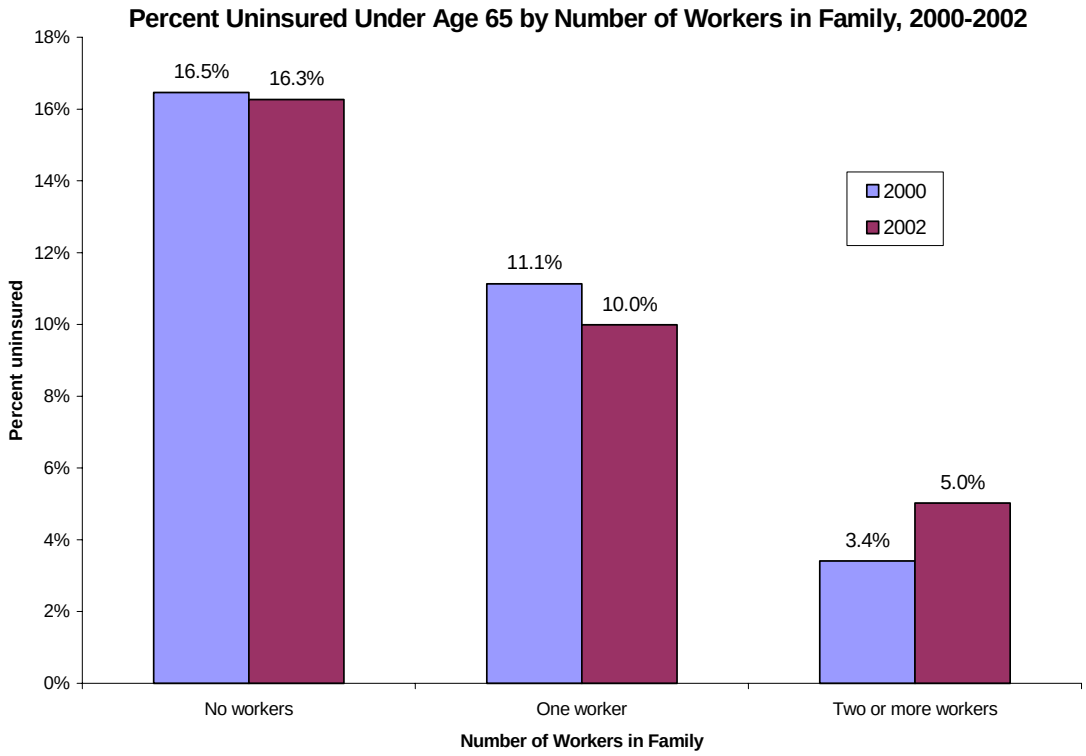
Source: Washington State Population Survey 2000v5M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-18



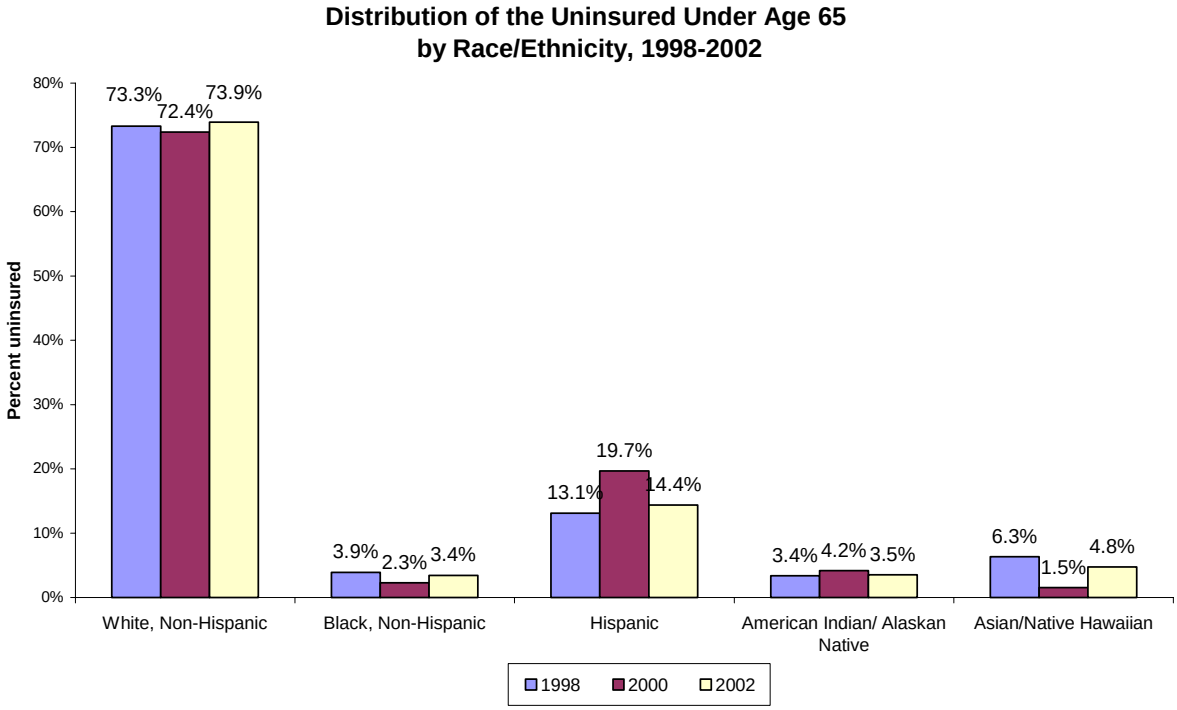
Source: Washington State Population Survey 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-19



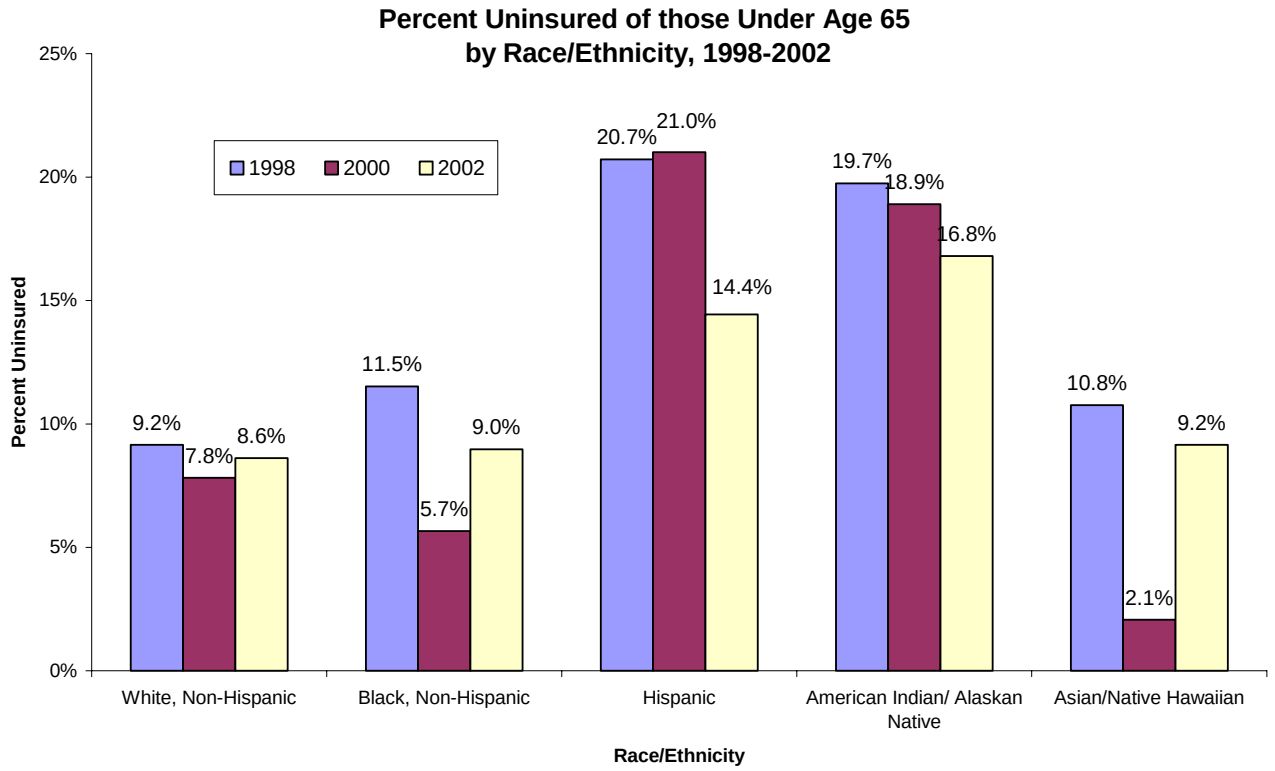
Source: Washington State Population Survey 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-20



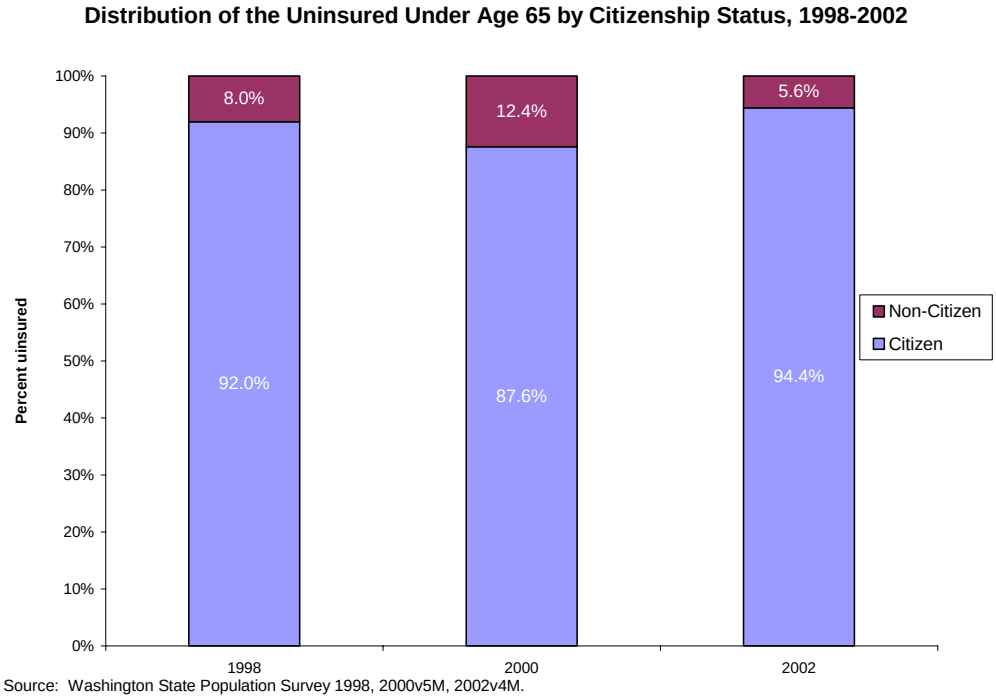
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-21



Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

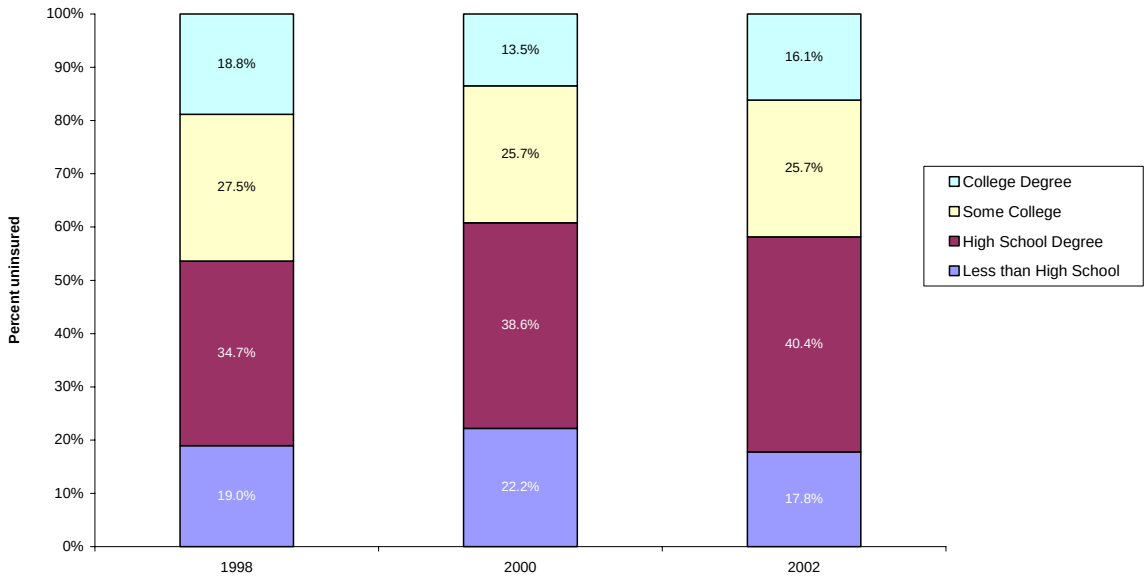
Figure 1-22



Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-23

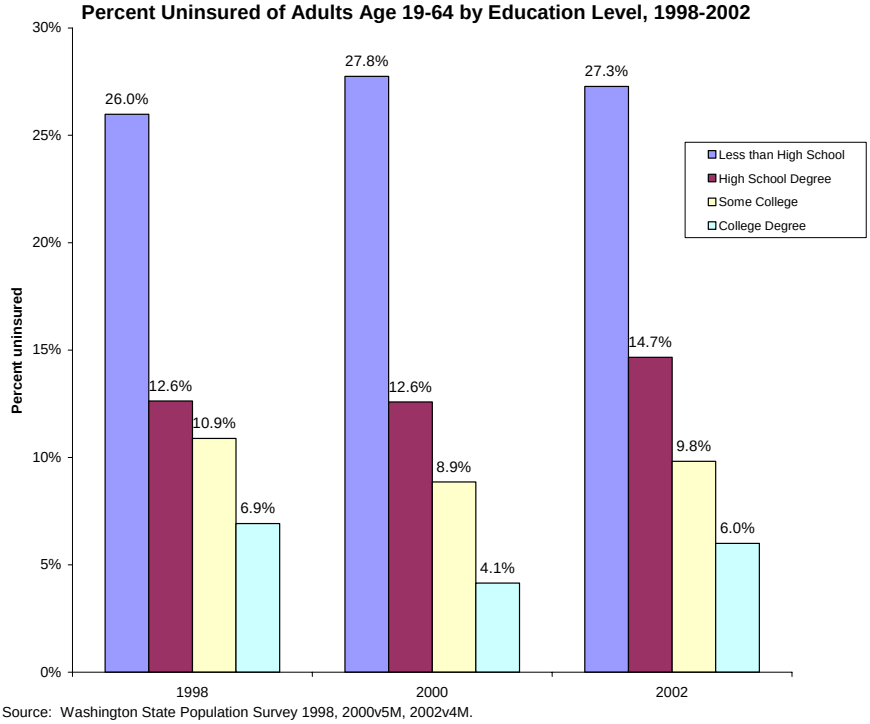
Distribution of Adults Age 19-64 Uninsured by Education Level, 1998-2002



Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

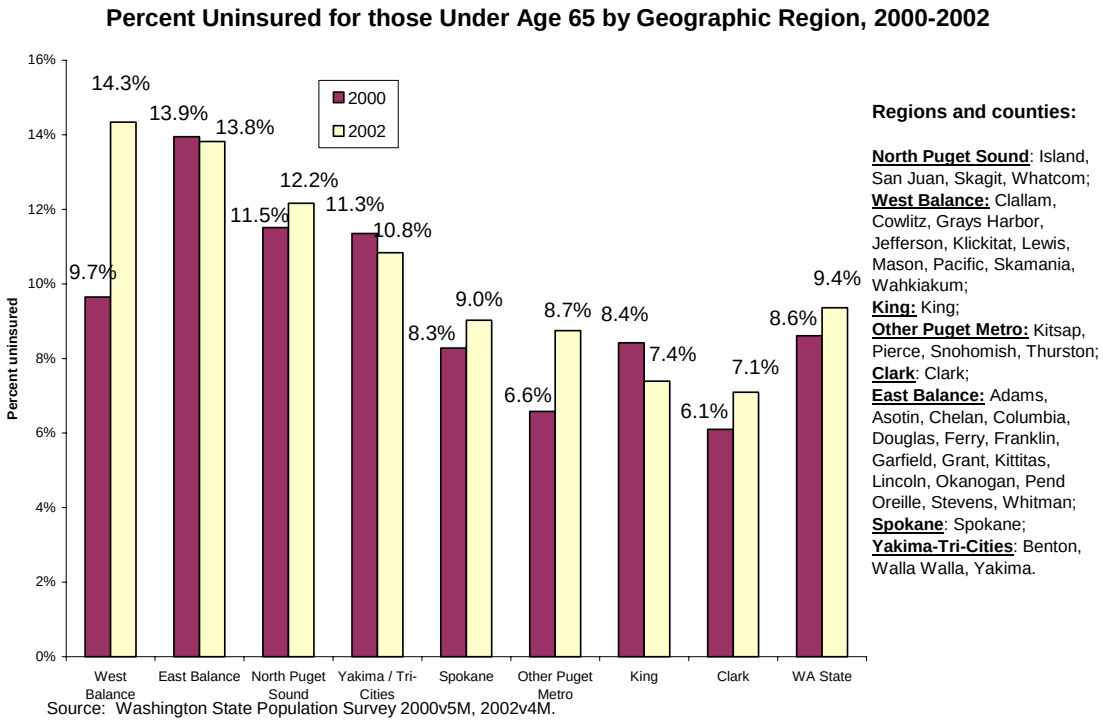
Figure 1-24

Percent Uninsured of Adults Age 19-64 by Education Level, 1998-2002



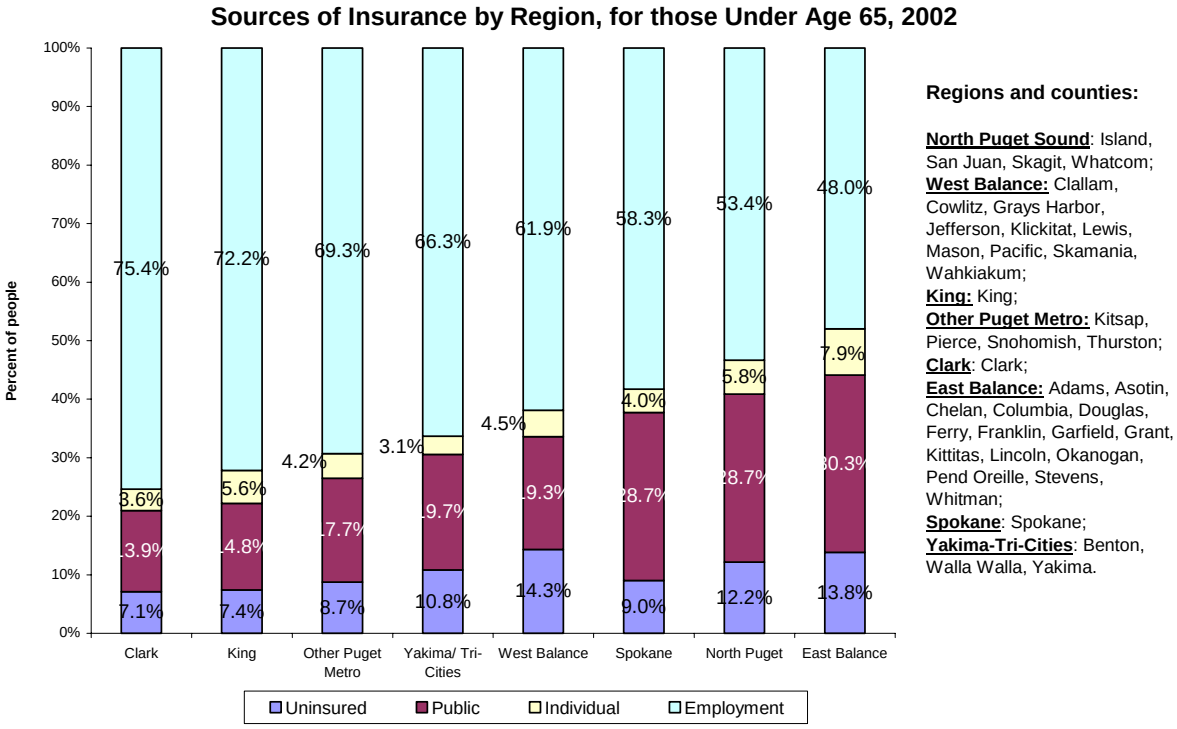
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-25



Source: Washington State Population Survey 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-26



Source: Washington State Population Survey 2002v4M
(Adjustments made to account for Medicaid underreporting are described in http://www.ofm.wa.gov/sps/index.htm)

Figure 1-27

Multi-State Integrated Database Variables

NAME (8 char max)	BRIEF DESCRIPTION (24 characters max)	DOMAIN*	WSPS Questionnaire Reference(s)
YEAR	Survey year	DI	System assigned
ID	Household	DI	System assigned
PNUM	Person number in house	DI	System assigned
REGION	Region	GE	REGN
FNLWGT	Non-Ins Analyses Weight - USE FOR ALL VARIABLES **NOT** IN HI DOMAIN	DI	Constructed
MAAWGT	Insurance Analyses Weight - USE FOR ALL VARIABLES IN HI DOMAIN	HI	Constructed
Q2P6	Sex	DI	Q2R6
AGE	Age	DI	Q2R7M, Q2R7D, Q2R7Y, Q2R8
AGECAT	Age Categories	DI	Constructed
Q2P16	Are you of Hispanic origin?	DI	Q2R16
Q2P13M1	Race	DI	AR213
RACE	Race incl Hispanic	DI	Constructed - Cross tab Q2P16 and Q2P13M1
Q2P14	Marital Status	DI	Q2R14
PARENTS	Number Parents	DI	Constructed
SINGSEX	Single Family Head Sex	DI	Constructed
WORKERS	Workers in Family	WS	Constructed
PARINS	Parents Insurance Status	HI	Constructed
Q215P	Served in Armed Forces	DI	Q215R
Q2P15	In Armed Forces Now	DI	Q2R15
Q215B1	Armed Forces Conflict	DI	Q215A
Q2P17	Education Level	DI	Q2R17
EDUCATN	Education Level Gps	DI	
EDUCATN	1 = Less than High School		Constructed - Q2P17<3
EDUCATN	2 = High School		Constructed - Q2P17=3, 4, 5
EDUCATN	3 = Some College		Constructed - Q2P17=6, 7
EDUCATN	4 = College Degree		Constructed - Q2P17=8, 9, 10, 11
Q2P18	Born US Citizen	DI	Q2R18
Q2P20	Year Came to US	DI	Q2R20
Q2P20CAT	Decade Came to US	DI	Constructed - Q2P20 = 1917-2002
CITIZEN	US Citizen	DI	Q2R21
PLACE1YR	Place Lived Last Year	GE	Q223A

NAME (8 char max)	BRIEF DESCRIPTION (24 characters max)	DOMAIN*	WSPS Questionnaire Reference(s)
Q3P2	Own or Rent Home	DI	Q3R2
Q3P2A	Home Financing	DI	Q2R2A
Q3P2B	Govt Rental Subsidy	DI	Q3R2B
Q3P5	Monthly Rent	DI	Q3R5
Q3P5CAT	Monthly Rent Gps	DI	Constructed
Q4P42	Chronic Condition	HS	Q4R42
Q4P4A	Physical Condition	HS	Q4R4A
Q4P4B	Learning Disability	HS	Q4R4B
Q4P4C	Grooming Disability	HS	Q4R4C
Q4P4D	Leaving House Disability	HS	Q4R4D
Q4P4E	Difficulty Working	HS	Q4R4E
Q4P4F	Difficulty Seeking Work	HS	Q4R4F
Q4P4G	Difficulty Workg for Pay	HS	Q4R4G
Q4P3	Employed Last Week	WS	Q4R3
Q4P6	Unemployment Reason	WS	Q4R6
Q4P8	Main Job Wkly Hrs Wrkd	WS	Q4R16
Q4P8CAT	Main Job Wkly Hrs Gps	WS	Constructed
Q4P9	Employer	WS	Q4R9
Q4P10	Employment Industry	WS	Q4R10 Coded with NAICS
Q4P12	Occupation	WS	Q4R12 coded with SOCS
MAJIND02	2002 Industry Recodes	WS	Constructed
HOURWEEK	All Jobs Wkly Hrs Wkd	WS	Constructed
WGHR1ST	Main Job Hrly Wage	IN	Q4R14-constructed
EARNINGS	Main Job Hrly Wage Gps	IN	Constructed
Q4P23	Temporary Work	WS	Q4R23
Q4P24	Reason for Temp Work	WS	Q4R24
Q4P26	Union Membership	WS	Q4R26
Q4P29	Job Laidoff Full Time	WS	Q4R29
Q4P31	Student Status	DI	Q4R31
Q4P30	Educational Institution	DI	Q4R30
Q4P33	Weeks Looking for Work	WS	Q4P32 = 1 and Q4P6A < 1/ Q4R33
Q4P33CAT	Time Looking for Work	WS	Constructed
Q4P34	Reason Not Look for Wk	WS	Q4R34
LFS	Labor Force Status	WS	Constructed
Q6SS1	2001 SSI Payments	IN	Q6SS1
Q6DI1	Investment Income	IN	Q6DI1
Q6FS1	Food Stamps	IN	Q6FS1
Q6GA1	Govt Cash Assistance	IN	Q6GA1
Q6CS1	Child Support	IN	Q6CS1

NAME (8 char max)	BRIEF DESCRIPTION (24 characters max)	DOMAIN*	WSPS Questionnaire Reference(s)
Q6UI1	Pension UI Workers Comp	IN	Q6UI1
FAMINC01	2001 Family Income	IN	Constructed - family sum from Q6P1A, Q6P4A and PNWAGE
FAMINCAT	2001 Family Income Gps	IN	Constructed
POVLEV	Family Income FPL	IN	Constructed
POVCAT	Family Income FPL Gps	IN	Constructed
PRIMECOV	Health Insurance Source	HI	Constructed
SRCECOV	Health Insurance Payor	HI	Constructed
INS_BHP	Basic Health Ins		Q7R3I
INS_MAA	Medicaid Ins		Q7R3D
INS_MDCR	Medicare Ins		Q7R3C
INS_EMP	Employer-based Ins		Q7R3A
INS_MIL	Military ins		Q7R3G
INS_OWN	Self-paid ins		Q7R3E
INS_OTH	Others paid ins		Q7R3K
INS_OUT	Outside employer pd ins		Q7R3J
CUR_INS	Insurance Status	HI	Constructed
Q7P7	Coverage Before BH	HI	Q7R7
Q7P6	Reason for no HI	HI	Q7R6
Q7P5	Employer Offers HI	HI	Q7R5
Q7P11	Health Status	HS	Q7R11
Q8P9	English language	DI	Q8R9
Q8P10	Non-English language	DI	Q8R10
Q4P16	Employer Size	WS	Q4R16
Q4P16CAT	Employer Groups	WS	Constructed

* Demographics & Identifiers (DI), Health Status & Utilization (HS), Health Insurance & Related Data (HI), Work Status & Employment-related Data (WS), Income (IN), Geography (GE)

SECTION 2. EMPLOYER-BASED COVERAGE

Employer-based coverage remains the primary source of health insurance coverage in Washington for workers and their dependents. Options for its expansion continue to be of particular interest to a broad set of Washington stakeholders. Although the employer-based coverage system has been steadily eroding in Washington, dropping from 70.9% in 1993 to 66.5% in 2002, the typical profile of employers who offer insurance and workers and their dependents who are covered has changed little. There is a solid body of literature on the patterns of health insurance coverage among workers. Large firms and firms that employ higher-wage workers offer insurance more often than small firms and firms that employ lower-wage workers. Consequently, uninsured workers are found disproportionately in firms smaller than 25 employees; in the agriculture, construction, retail and trade industries; and in the private sector rather than the public sector. And they are more likely to work part-time or in seasonal activities, be low-wage workers; and those who live in low-income households[1]. As with the patterns of uninsurance described for individuals and families, Washington parallels the national picture.

The complication for Washington has been its high unemployment rate in recent years, which consistently tracks higher than the national average due mainly to a relatively high concentration of resource-based industries[2]. Although down from an average of 7.5% in 2003 (6.0% nationally) to 6.2% in August 2004[3] (5.4% nationally) the recovery trend has not been as fast as anticipated. Manufacturing, construction, leisure and hospitality sectors have been hit hard. Although workers are now becoming employed, debts built up during extended periods of unemployment make health insurance premiums a commonly unaffordable expense. Furthermore, as job growth occurs many workers are returning to lower paying jobs (those less likely to offer health insurance) in hospitality, finance, retail and segments of health care and business services[4]. Manufacturing, in which 68,000 jobs have been lost since January 2001, and for which more jobs are relatively high-paying (and tend to come with health insurance benefits), has yet to recover.

Significant work occurred in Washington in the mid 1990s to understand the characteristics and motivations of employers who offer and do not offer coverage. Analyses conducted during our first SPG built upon these previous descriptive efforts, with a particular emphasis on understanding more about small employers. With access to comprehensive albeit proprietary data sources, our consultants developed a broad profile of Washington's employers and their workers, to help understand the characteristics and circumstances surrounding the likelihood that a worker is employed in a business offering health coverage[5]. More recently we focused efforts on identifying local data sources for replicating and refining this work, to establish a template for future data gathering and analysis efforts and enhance our historical picture of employer-based coverage. We have tried to capture the challenges since they have caused us to profile Washington's employers and workers using a variety of data sources, none of which tells a complete story in and of itself.

---

[1] Greenman, E., et al. 2001. Workers Without Health Insurance. *Urban Institute and W.K.Kellogg Foundation.* Available at www.wkkf.org/pubs/healthcommunityvoices/pub712.pdf

[2] See Washington trends available at: www.ofm.wa.gov/trends/htm/fig105.htm.

[3] See September 14 news release available at: http://fortress.wa.gov/esd/portal/info/newsroom/releases/nr091404.htm

[4] Holt S., and Blanca Torres articles in Seattle Times. Jobless Find New Work, Not Old Standard of Living, July 14, 2004. State Jobless Rate Inches Higher, September 15, 2004.

[5] Research reports are available at: http://www.ofm.wa.gov/accesshealth/accesshealth.htm

A. Data Sources:

Continuing the theme that local data bring a level of credibility and depth not available from national surveys, we began our more recent analysis of employers and employees using data gathered in WSPS 2002. However not all data constructs important for analysis of employers, or workers and their dependents, are directly measured in or able to be derived from WSPS alone. In some cases responses are skipped by too many respondents (e.g., employer type); not consistently provided (e.g., employer size, self-employed status); inadequately coded (e.g., labor force status of non-respondents) or the information is not known by employees (e.g., details about employer behavior; employee wage-mix) and therefore not collected.

Our original SPG consultants resolved these problems by synthetically matching each worker in the 2000 WSPS to an employer in the 1997 RWJF Employer Health Insurance Survey (EHIS)[6], and thereby attaching all the characteristics of a single employer to each worker (e.g., industry, size of firm, employee wage-mix, part-time/full-time mix, seasonality etc). In addition they imputed premiums that would have to be paid for workers in firms that do not offer coverage based on understanding characteristics of firms that do offer coverage. Details of this approach are outlined at: http://www.ofm.wa.gov/accesshealth/research/31appenab.pdf. To repeat this process we looked for a source of current, local, employer data to replace EHIS data that were no longer accessible and were perceived to reflect employer status prior to Washington's economic recession.

A short, fill-in-the-blanks survey of employers is conducted semi-annually by the Employment Security Department (ESD) to capture critical labor market information on job vacancies. In late 2002 we collaborated with ESD to pilot expansion of the survey to collect employer benefits information. Although not comparable with the sophistication (or cost) of the WSPS, it sampled almost 11,000 employers and gathered a set of health insurance coverage details. Unfortunately we found puzzling discrepancies from official labor market data in our follow-up analysis. These were isolated to an uncorrectable weighting issue and we were unable to generalize the 2002 survey results to all employers.

However, we were encouraged at the potential for replicating our consultants' initial SPG research using ESD data. We suggested changes to the October 2003 job vacancy survey to expand data collected on employers' offer of health insurance, although the number of changes was restricted to avoid compromising employer response rates on job vacancies, the survey's primary data gathering purpose[7] (See Figure 2-1 for a sample of the Employee Benefits section). The weighting methodology was corrected and we then attempted to match ESD employer data with WSPS 2002. This time insurmountable problems occurred as a result of incomplete WSPS responses that allowed us to match less than 50% of workers to an employer. We hope that this issue will be resolved by improvements to the WSPS 2004 survey so we can continue this effort in our future SPG activities.

B. Profile of Washington's Employers and Employees

[6] RAND designed and the Robert Wood Johnson Foundation funded the Employer Health Insurance Survey (EHIS) in 1993 and 1997. It sampled private employers included in Dun's Market Identifiers and collected data from local, state and federal government agencies to represent public employers. These data are proprietary and not available for public use, however they were accessible to our SPG because RAND participated in our consultant consortium. For ongoing analysis the survey is not being repeated.

[7] The 2003 Washington Benefits Survey was distributed to a sample of 20,484 employers with a 44% response rate. It earned ESD the 2004 Labor Market Information Communications Publication Award from the National Association of State Workforce Agencies.

Uninsureds' Worker Status

Because of the high interest in 2003-2004 by state policy makers in employment-related coverage options, Figure 2-2 became a "favorite" at policy discussions. How many of the uninsured might a "pay or play" scheme impact? What if it affected only full time employees? How many small firms are not offering coverage? Unfortunately, we had to construct Figure 2-2 based on initial SPG research rather than our most recent data sources, for all the reasons discussed earlier. Although "old" data, the fact that it was Washington-specific and consistent with national information, gave it the needed "face validity" to inform policy discussions.

In addition, we were reminded that information "packaging" is important. When presented in new ways and shaped to the interest of the moment, existing data can be a valuable foundation for policy discussions. We learned that it is not always essential to have *new* data; what is important is the relevance and usefulness of the information.

Finally, construction of Figure 2-2 clearly pointed out gaps in information. These include characteristics of self-employed workers and their dependents (approximately 35% of the uninsured in 2000); and characteristics of firms in which workers do not take-up insurance even when they are eligible (17% of the uninsured in 2000).

Concurrent with data gathering efforts we have completed further, although limited, analysis of employer-based coverage based on a variety of sources that include the 2003 ESD survey, our original SPG research, WSPS 2002 and MEPS 2001. These data sources do not cover exactly the same subset of Washington firms or workers; the 2003 ESD survey includes firms with 4 or more employees; our original SPG research includes all firms and workers and in some cases, their dependents; WSPS does not include firms; and MEPS 2001 does not include self-employed workers or any workers' dependents. As a result, our analysis is rather a patchwork of information with some data gaps.

Distribution of Washington Business

In 2002, approximately 60% of Washington's workers[8] were employed in firms with 50 or more employees (Figure 2-3), although these firms made up less than 4% of the number of firms in the state (Figure 2-4). Over 80% of firms were small, with fewer than 10 employees, and these firms employed only 15% of Washington's workers. This distribution remains virtually unchanged in 2003.

The distribution also is reflected in the MEPS 2001 data in Table 2-1. We found reworking and comparing different data sets in this way to be useful and important. Although our data sources don't cover exactly the same subset of firms and time frame, the comparison of analyses from each source allowed us to triangulate on the story in Washington and build a greater level of comfort and face validity in our findings.

Common Benefits

National studies show that employers who do not offer health insurance tend not to offer other benefits, such as paid sick leave and paid vacation[9]. From the 2003 ESD survey we find that for the

[8] Self-employed workers are counted as individual firms with no employees.

[9] For example, Sara Collins et al. 2004. Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace. *The Commonwealth Fund.* Can be retrieved at www.cmwf.org

most part, firms that offer health insurance also offer paid vacation and paid sick leave, benefits often taken for granted. Firms that did not offer paid vacation also did not offer health insurance.

For full-time employees, paid vacation is the most commonly offered benefit and health insurance is the second most common. Eighty-two percent of Washington firms offer paid vacation and 76% offer health insurance to their full-time employees (Figure 2-4). The story is quite different for part-time employees for whom only 36% offer paid vacation and 26% offer health insurance. This disparity is consistent across all regions, industries, and firm sizes.

Firm Size

Size of firm makes a difference in the offer of health insurance (Figure 2-5). **Large firms are much more likely to offer coverage to their workers than small firms**. Almost all (97%) of firms with more than 100 employees offer coverage to their full-time employees and more than half (53%) offer coverage to their part-time employees. However, only 72% of smaller firms with between 4 and 19 employees offer coverage to their full-time employees and fewer than a quarter of them (23%) offer coverage to their part-time employees.

Although it offers the most current picture of Washington business, the ESD survey does not tell the full story of the smallest firms or the self-employed. For that story we revert to findings from MEPS 2001 (Table 2-1) and our initial SPG research, which show that **between 49% and 54% of workers in firms with fewer than 10 workers are offered coverage.** This pattern holds even when adjustments are made for factors related to firm size, such as unionization, seasonality and presence of low-wage or part-time workers.

However, regardless of firm size, **when workers are offered health insurance and they are eligible, they typically do enroll** (Table 2-1). Excluding the self-employed who made up approximately 35% of the uninsured in 2000, the MEPS 2001 survey indicates that approximately 86% of Washington workers are employed by firms that offer health insurance; 77% of these workers are eligible for coverage; and 85% of those offered and eligible are enrolled. In particular, over two-thirds (about 69%) of workers in small firms that are offered coverage are actually eligible and most of those eligible (89%) are enrolled. Workers in small firms who are eligible for coverage are much more likely to enroll than workers in the largest firms (82%).

Industry

Industries differ in their likelihood of offering health insurance. Local, state, and federal government agencies, and firms engaged in finance and insurance are most likely to offer insurance while firms engaged in the agriculture, forestry, or fishing industries are the least likely (Figure 2-6).

Industries less commonly offering health insurance to full-time workers also tend to pay lower average wages (Figure 2-7). Annual average wage for Washington firms was $38,249 in 2003. Industries with below average wages and low rates of health insurance coverage include retail trade, accommodation and food services, and agriculture, forestry and fishing. Although average wages in health care were low, over 90% of health care firms offered health insurance to their full-time workers.

Although there is variation in the availability of health insurance across industry, workers in large firms have higher sponsorship and eligibility, but not necessarily take-up rates, regardless of industry. As noted, firm size drives the opportunity for coverage more often than industry.

Wages

From our original SPG research we determined that characteristics of a firm's workers are also related to the likelihood that insurance is offered. Although much emphasis is placed on firm size, regardless of firm size, the average wage paid by a firm is an important indicator of offer of coverage. **Workers in firms with a large share of low-wage workers (and low average wage) are less likely to be offered health insurance than workers in firms with higher-wage workers (and higher average wage)** (Figure 2-8).

Dependents

Not surprising, the ESD survey confirms that dependent coverage is not offered as frequently as coverage for workers but the general characteristics of firms that offer coverage to workers apply to dependents as well. In Washington, the availability of health insurance is highest for dependents of: full-time workers; workers in large firms; workers engaged in public administration, finance and insurance, and mining and utilities; and firms located in urban Seattle-King County rather than in the more rural regions of Eastern Washington.

Reasons for Not Offering Coverage

Overwhelmingly, expense is the reason given by firms for not offering health insurance to at least some of their employees (73% of firms not offering health insurance) – not surprising given that national studies show that health insurance premiums have climbed rapidly in recent years, and are continuing to climb at double-digit rates[10]. For some of the largest employers in Washington, health insurance coverage is becoming a large financial drain. Starbucks for example, pays more in health insurance for its employees than it does in raw coffee[11]. In the ESD survey, expense was more often an issue for the smallest firms (4 to 19 employees) than the largest (100 or more employees). A surprising 11% of firms say they don't know why they don't offer a health insurance benefit, although estimates are based on responses given typically by staff in human resource departments who really may not know. A further 8% of firms don't offer coverage because their competitors don't.

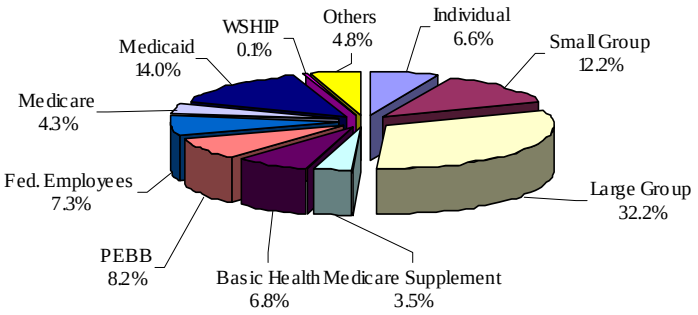
[10] John Gabel et al., "Health Benefits in 2003: Premiums Reach Thirteen-Year High as Employers Adopt New forms of Cost-Sharing," *Health* Affairs 22 (September/October 2003): 117-26. Employer Health Benefits 2004 Summary of Findings, Kaiser Family Foundation and Health Research and Educational Trust.

[11] Remarks made by CEO of Starbucks at NGA meeting in Seattle, July 19, 2004. General Motors made the same comment with respect to the cost of health insurance compared with raw steel.

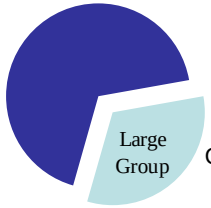
FIGURE 3-1. **WASHINGTON STATE PLANNING GRANT ON ACCESS ON HEALTH INSURANCE**
WASHINGTON'S INSURANCE MARKET, 2002

Private Insurance Carriers' Market Composition (2002)

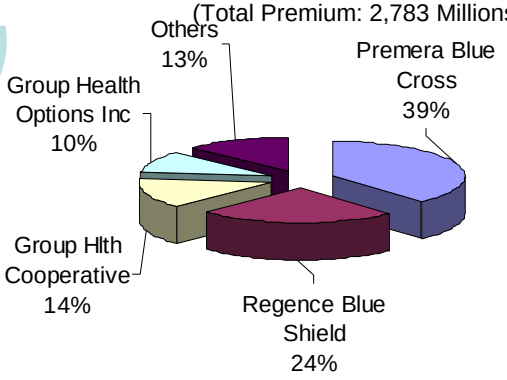
2002 Total Enrollment: 2,755,491
(51% of Total Insured in Washington State)



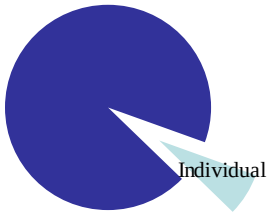
Private Health Care Insurance Market Segment Large Group (2002)



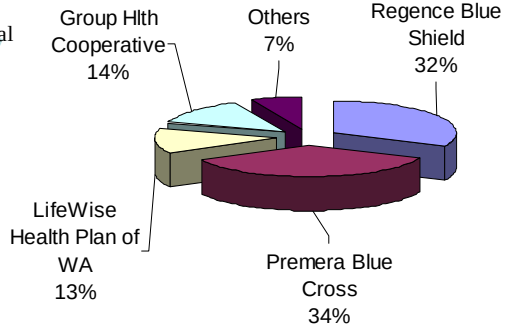
2002 Total Enrollment: 1,193,743
(Total Premium: 2,783 Millions)



Private Health Care Insurance Market Segment: Individual (2002)

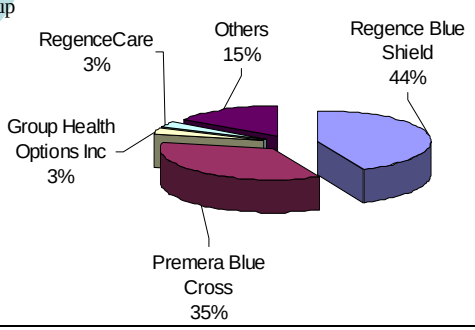


2002 Total Enrollment: 192,887
(Premium: $330 Millions)



Private Health Care Insurance Market Segment Small Group (2002)

2002 Total Enrollment: 361,429
(Total Premium: 810 Millions)



Source: OIC 2003 Task Force - 2002 Financial statements filed with Washington OIC and NAIC; Washington State Population Survey 2000v4.

Figure 3-2.

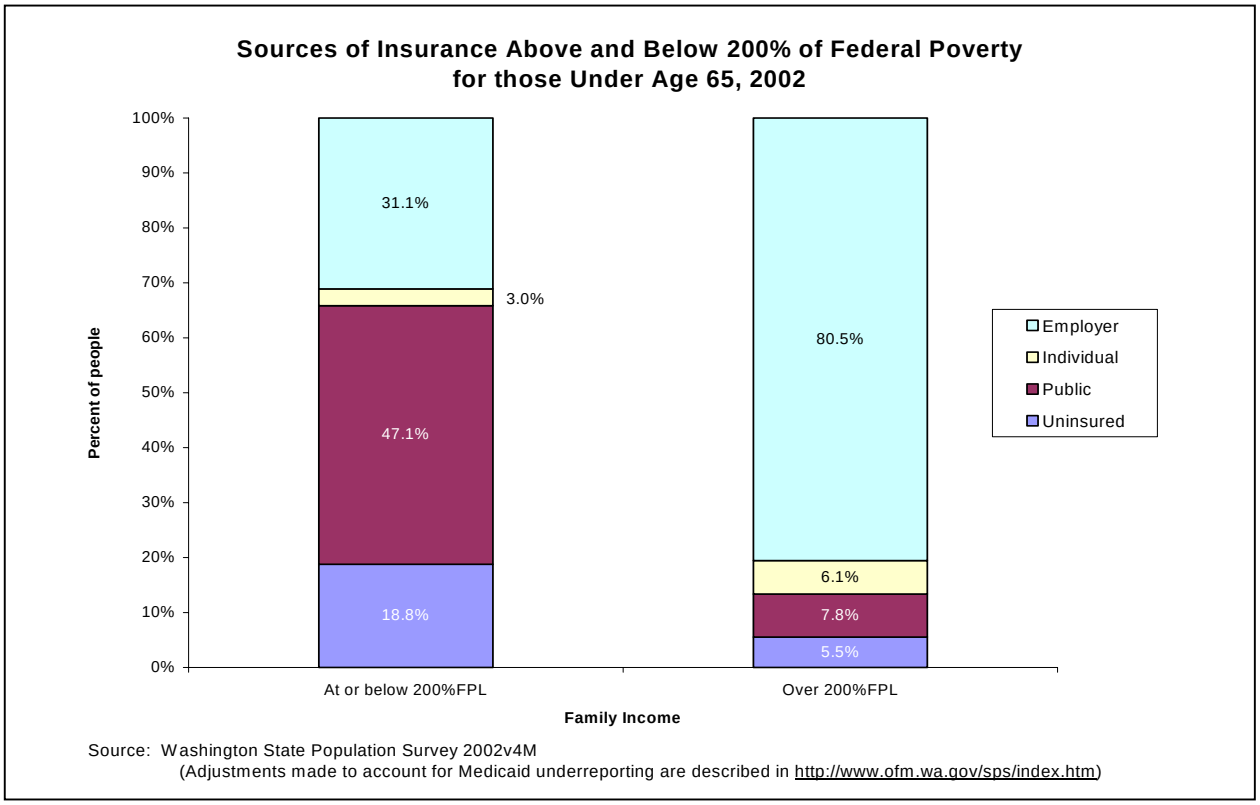
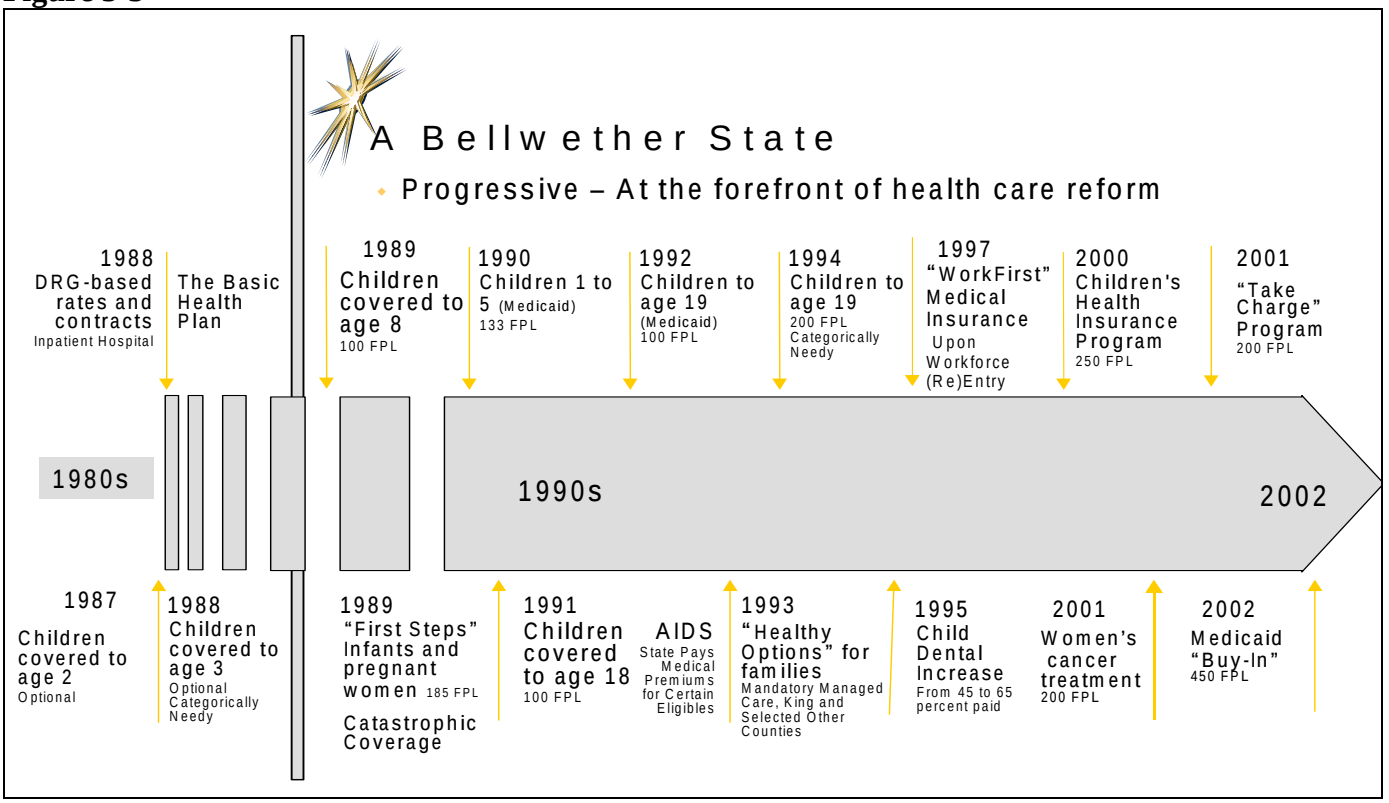


Figure 3-3



"Bellwether" chart provided by State of Washington, Department of Social and Health Services.

Figure 3-4

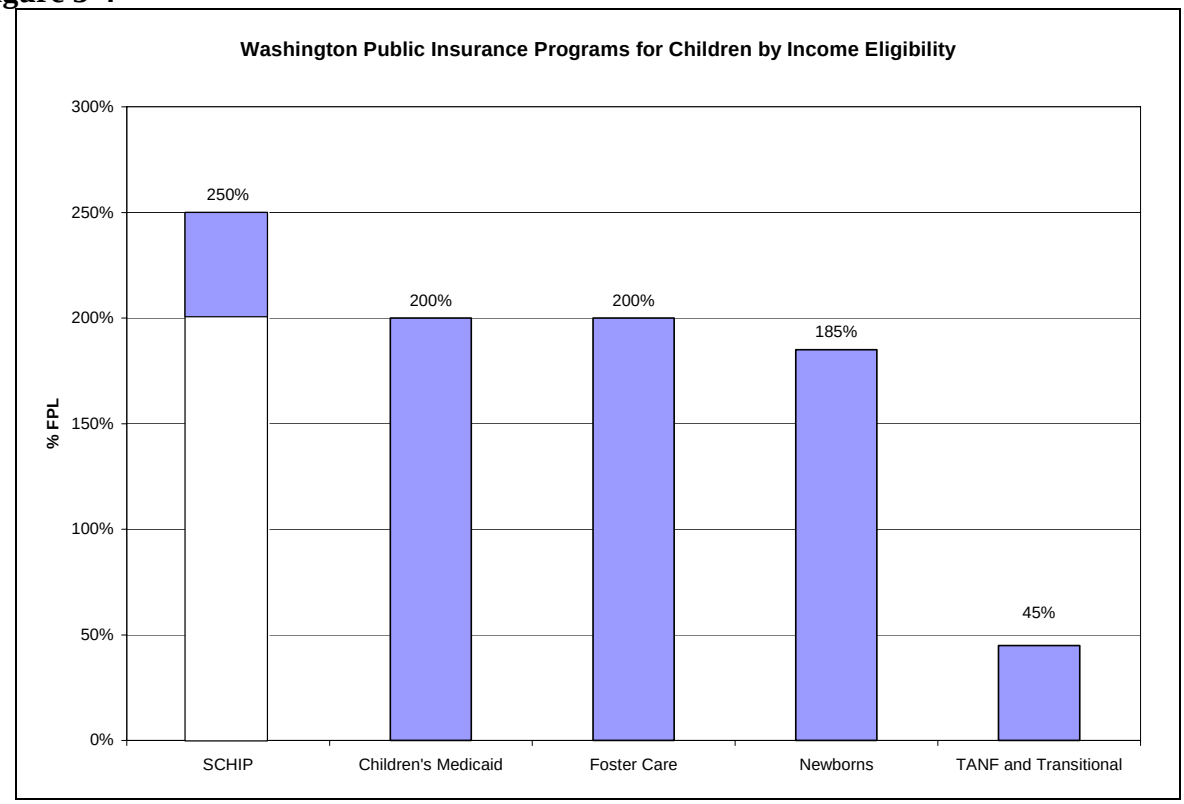
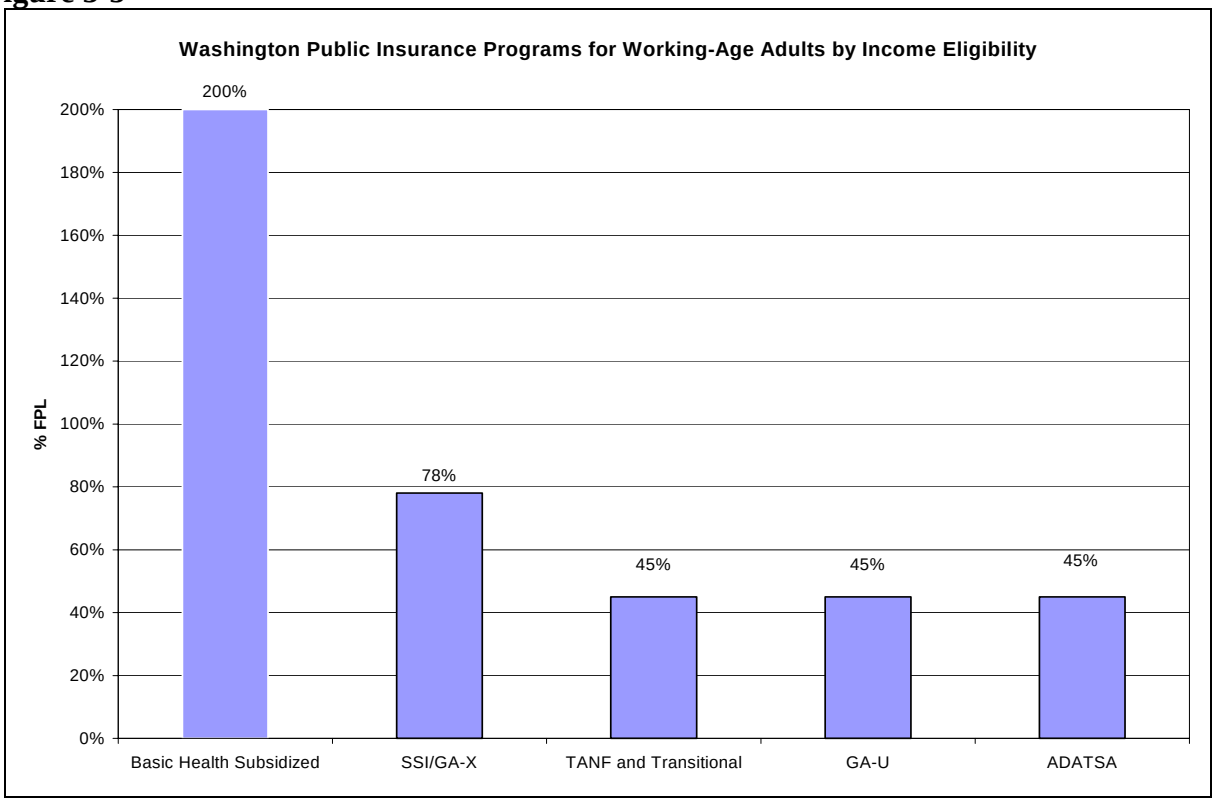


Figure 3-5



SECTION 4. OPTIONS AND PROGRESS IN EXPANDING COVERAGE

In the 1980's and 1990's Washington was a leader on many coverage fronts – expansion of coverage for low-income working (Basic Health) and for children & their families (Medicaid coverage for children up to 200% federal poverty before SCHIP); pre HIPAA market reforms; early adoption of a high risk pool; sweeping health care reform to achieve universal coverage (subsequently repealed); dedication of tobacco litigation dollars to health care (with an emphasis on prevention).

More recently, particularly in light of the state's prolonged recession and resulting budget deficits, public policy vis-à-vis coverage has focused on:

- maintaining public programs for the most vulnerable,
- providing a supportive environment for employers to offer coverage and individuals to purchase it, and
- assisting the clinic-based safety net system with funds and regulatory support.

Notwithstanding these efforts, people unfortunately have still lost coverage, most notably in public programs – immigrant children were moved from Medicaid to Basic Health and did not re-enroll as hoped, Basic Health coverage slots were decreased and funded by dollars intended (via a citizen's initiative) for expansion, Medicaid administrative changes resulted in much larger than anticipated exits of children, major changes to Basic Health cost-sharing (including deductibles and co-insurance) were implemented (evaluation of impacts is underway).

However, there also have been a few recent "incremental" bright spots including coverage for the working disabled, opening Basic Health to people eligible for Trade Act coverage, resolving an individual market collapse, forestalling a small group market "affordability" crisis, and Governor Gary Locke's decision to delay until July 2005 premiums for some Medicaid children (those below 200% federal poverty); although children in SCHIP (201% - 250%) saw an increase in premium sharing effective July 2004.

All in all, the mixture of Washington's progressive social policy, conservative fiscal policy (e.g., 1993 passage of spending cap), and recent economic downturn has produced a current "health system for low-income individuals [that] seems to be in a fairly fragile state".[1]

The irony of working on a grant to achieve broader coverage, simultaneous with watching the uninsured rate increase, does not escape us. It has been an on-going challenge.

In the following sections we describe a select set of coverage and access activities conducted largely in 2003-04 and for which State Planning Grant (SPG) support has been invaluable. Before doing so, it's important to note that much of our work has been of a support nature and is somewhat difficult to capture succinctly – answering a myriad of ad-hoc questions, participating in policy and design discussions organized by a variety of groups, creating a "presence" in the executive branch to ensure that Washington's uninsured aren't lost in the shuffle of budget deficits. We do our best to show the essence of our support role but the exactness is somewhat elusive. (Note: Most Figures referenced in this section are included at the end of the section.)

[1] Holahan, John and Mary Beth Pohl. 2002. "*Recent Changes in Health Policy for Low-Income People in Washington*." Washington, D.C.: The Urban Institute. The quote used is as true today as it was when Holahan & Pohl wrote it.

A. The Range of Coverage Efforts

Over the last couple of years, coverage options that have risen to the top of the *state* policy discussion list include covering all children, revising the small group market to assist small employers in providing coverage, "stimulating" employers to provide coverage, stabilizing the private market, and redesigning public insurance programs. In Figure 4-1 we elaborate on state policy efforts in these areas.

In addition to this state policy focus, there have been a variety of *other activities* in Washington related to coverage and access. In Figure 4-2 we try to capture as many of these as possible and link them to the initial SPG research on potential policy options. In the following sections we briefly elaborate on a few of these.

Finally, in Appendix 1 we provide examples of the types of data and policy questions responded to by SPG staff in support of coverage discussions and programs.

B. Community-Based Efforts

We are highlighting the following three community-based efforts because (1) they demonstrate different aspects of the SPG program strategy to support others' efforts to enhance coverage, (2) the initiators represent different types of "communities" (providers, occupation-based, public health) with which we have collaborated, or (3) the efforts represent a diversity of access and coverage thinking, as well as incremental and transformative approaches.

Community Health Works[2] is an example of a community activity with which we have had a long-standing relationship. The SPG program chose to become closely involved in this activity because of its "transforming health coverage and access" orientation. The majority of coverage options in-play these days are incremental – Community Health Works was an opportunity to collaborate with a dedicated group of local providers, public health officials, policy shapers, consumers, brokers and others to design a program that would provide 100% access for all low-income (below 250%) residents of a five county region in Washington state.

The goal of this project is to pilot a community-based coverage, delivery and administration model sometime around 2008. Although still a work-in-progress, one of most "transformative" pieces under discussion is the development of a "Community Health Management District" (CHMD). Because the governance of the CHMD would be local, it would reflect local values in terms of access-to-care guarantees (what care should everyone in the community have access to), in terms of making service delivery better (collaborative and subsidized information technology; shared provider and resident responsibility for ensuring a medical home for everyone), and in terms of managing and leveraging funds to pay for the "community-responsibility" piece of health care access (lower individual costs for care via community-shared reinsurance for higher costs). Although it has evolved significantly since then, one of the "birth places" for this idea was a SPG-sponsored technical assistance meeting conducted in May 2002 on Community-

[2] *Community Health Works* (previously the 100% Access Project) is funded by the U.S. Department of Health and Human Services, Health Resources & Services Administration (HRSA), Bureau of Professions' Community Access Program (CAP). More information is available from Kristen West or Dan Rubin at CHOICE Regional Health Network, 2409 Pacific Avenue SE, Olympia, WA 98501, 360-493-4550.

Based Purchasing and Coverage.[3] Emphasizing that the CHMD model is a work-in-progress, a recent vision of the model is given in Figure 4-3.

Most recently, health coverage and access projects from around the state have come together as *Communities Connect.* Their commonality is based on six principles (see side box) that are also the guiding principles of the Community Health Works project and serve to demonstrate the growing, community-driven, wave of change moving across Washington

"We believe we can deliver better health care for more people at less cost by formalizing community collaboratives throughout Washington State who will be "in action" on six interdependent principles: 1) Stabilize the safety net of hospitals and practitioners who provide care to the low-income and uninsured; 2) Create flexible and attractive ways for employers to financially contribute towards coverage for low-wage workers; 3) Enroll people with limited incomes in a medical home, starting with children; 4) Deliver evidence-based and patient-focused care through health teams; 5) Reduce costs and redirect savings to cover more people; 6) Purchase services of greater value to the community through Community Health Management Districts (CHMDs)."

Community-Based Health Care, Issue Paper Draft #3, Communities Connect, available from Choice Regional Health Network, Community Health Works program.

Washington Artists Health Insurance Project[4] (WAHIP) is an example of an activity in which we have just recently become involved. In fact, the project itself is quite recent and held its first "kick-off" meeting with representatives of the arts community in September 2004. Among the goals of this project are (1) develop new strategies to improve artists' access to health insurance in Washington state and (2) serve as a national "process and implementation" model for other state and community efforts to enhance coverage options that benefit artists.

Washington's SPG program is particularly interested in this effort for several reasons. First, we see an opportunity for this group to serve as a proxy for a changing work force. The rise of contract, temporary, contingent, multiple-employer workers fits the long-standing fluid

[3] State Coverage Initiatives (SCI) staff assisted in organizing this invitation-only meeting attended by community-based coverage champions and facilitated by several national experts. SCI is a program of The Robert Wood Johnson Foundation.

[4] *WAHIP* is part of Leveraging Investments in Creativity (LINC), a 10-year national effort to strengthen artists' ability to work in their professions and to connect with their communities. Funding for LINC is provided by the Ford Foundation, Allen Foundation for the Arts, Nathan Cummings Foundation, John S. and James L. Knight Foundation, and the Rockefeller Foundation. More information about WAHIP is available from Claudia Bach, 7702 14th Avenue NW, Seattle, WA 98117, 206-789-2418, Claudia@advisarts.com.

employment pattern of many artists and those who work in arts-related occupations (e.g., set designers). If we "use artists to see beyond artists" and focus on coverage options that meet the "work styles" of this group perhaps we have a head-start on forging viable coverage approaches to meet the needs of a changing future workforce. Second, we see this as an opportunity to bring new thinkers to the table. Those of us who have worked in health policy for years can have a tendency (although we certainly fight it) to believe we've "been there done that" and perhaps get myopic in our thinking. Here is a new force in Washington, the arts community, that is willing and enthusiastic to bring its resources and creative talent to this issue. Finally, we believe the resources of the SPG and the needs of the WAHIP are aligned (see side box) – we have an on-going strategy of supporting, through research and policy analysis, *any* group that is willing to tackle *any* aspect of "covering the uninsured". This certainly is the case with the artists' initiative.

> "With regard to health and retirement insurance and similar benefits, we need (a) much better and more up-to-date information about who has insurance and who does not; (b) information about the various and most advantageous ways in which artists currently get insurance and also promising ways in which they may be able to obtain it in the future; and (c) information about advocacy efforts for heatlh and retirement insurance inside and outside the cultural sector. Specific information about groups with which artists may become allied would also be useful."
>
> Jackson, M.R. et al. *Investing in Creativity: A Study of the Support Structure for U.S. Artists*. Washington D.C.: The Urban Institute Press, pgs 79-80.

We currently are exploring with WAHIP leadership the different ways in which we can collaborate. On a range of less-to-more involvement these include: participating as one of a consortium of experts that guides the project, exploring State Population Survey data to see if information about artists can be reasonably isolated (and if so, conducting basic analyses to identify gaps in knowledge), providing technical assistance in designing a survey of Washington artists and arts-related workers regarding their insurance status and needs, contributing resources for analysis of survey results, jointly sponsoring a meeting of national experts to explore coverage options, providing policy assistance in evaluating the viability of options, collaborating on locating resources and partners to implement a demonstration.

Although our involvement has been minimal to-date (attendance at a few meetings and phone conversations), we chose to highlight this activity because it demonstrates the on-going interest in Washington of finding coverage options, that there are new groups willing to struggle with old issues, and that the support provided by the SPG program continues to be of value.

Kids Get Care[5] is our last example of a community-based effort. We have chosen to highlight it for several reasons. One, it's an example of another aspect of our SPG strategy on achieving coverage -- that is, we literally have had no visible roll in supporting this effort; rather, we have

[5] *Kids Get Care* is an initiative of the King County Health Action Plan and received initial funding from the HRSA Community Access Program. For more information contact Susan Johnson, Director, King County Health Action Plan, 206-296-4669, susan.johnson@metrokc.gov.

quietly advocated for its "principles" through policy and budget discussions in the Governor's Office, discussions with legislative staff, and through our involvement in other community-based efforts at coverage. Second, it turns conventional thinking about coverage and access 180 degrees – rather than viewing coverage as providing access to care, it uses access to care as an entrée for showing people the value of insurance (access has "face validity" for almost anyone while insurance does not) and moving them into coverage. Third, it practices what is so commonly preached today – evidence-based, preventive medicine with a positive return on investment. By ensuring "that children, regardless of health insurance status, receive early integrated preventive physical, developmental, mental health and oral health services through attachment to a health care home"[6] the program is building on evidence that 2-year olds who have up-to-date Well Child Checks are 48% less likely to have avoidable hospitalizations.[7] And finally, we are highlighting it because there is growing interest in Washington in covering all children and the *Kids Get Care* approach could be an integral step in that strategy (see side box).

Integrating the Kids Get Care Approach Into an Effective Cover-All-Kids Strategy

- Couple Kids Get Care program (i.e., medical home using best practices in preventive care) with undoing administrative barriers to public programs recently put in place.
- Engage and financially support community partners in building "medical home" capacity.
- Engage state and community partners in doing outreach to reach all kids currently eligible for state programs.
- Expand state programs to 300% federal poverty to capture most of the rest of the kids. (Washington SCHIP currently goes to 250% federal poverty; combined with Medicaid and Basic Health, approximately *68% of currently uninsured children are eligible* for coverage.)
- When the kids are covered, cover their parents. Overwhelmingly, research indicates that (1) parents' use of services strongly influences their children's use of services, (2) uninsured parents are more likely (than insured) to delay or forgo getting care for their insured children, (3) uninsured parents are less likely (than insured parents) to be effective in working with the system that covers their child. Thus, neglecting the insurance status of parents may have the unintended effect of reducing the impact of insurance coverage for children. If we want to get maximum value from the coverage we deem a priority (i.e., coverage for children), we need also to consider covering the parents of these children.
- Finally, consider auto-enrollment in public coverage for kids who lose coverage because their parents lose job(s), while the parent searches for employment (a kind of "unemployment" health assistance program).

C. Impacts of Premium & Cost-Sharing Changes on Low-Income Individuals & Families

Assisting public programs in designing and conducting evaluations of the impacts of premium and cost-sharing changes on low-income individuals and families has been a major focus of the SPG during the last year. There is good news and bad news regarding our progress.

[6] *Kids Get Care* program materials available at www.metrokc.gov/health/kgc.

[7] Hakim, R. and Bye, B. Effectiveness of Compliance with Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries, *Pediatrics*, 108: 90-97, July 2001.

The good news is that the need for such an evaluation specific to the Medicaid program was forestalled by Governor Gary Locke's June 2004 decision to delay, at least until July 2005, implementation of premium sharing in Medicaid.[8] It's hard to predict if the need will re-arise come July 05 – a number of factors come into play including state revenue levels, health inflation and cost increases, and the outcome of the November 2004 election (a new Governor and potentially many new legislators).

The (sort of) bad news is that the evaluation work with the Basic Health (BH) program has not reached the point where results are available for this report, although analysis currently is underway and results will be available shortly.[9] Thus, the focus of our comments in this progress report is mainly on background, process, methodology and lessons.

Background: In the 2003 legislative session, during the throes of one of the longest recessions and deepest budget deficits in recent Washington history, policy and budget decisions were made to implement premiums for (optional) children's Medicaid coverage (effective February 2004) and to reduce the actuarial value of the state's BH program[10] by 18% (effective January 2004). The state was in the process of obtaining (and ultimately received) a waiver for premiums in Medicaid; BH is a state-only program so federal waiver issues do not apply.

Initially, Medicaid was to charge premiums for children at and above 100% federal poverty. Over time, who would be charged and how much was the subject of strong debate. The final outcome, or so we thought, occurred with the 2004 budget authorizing a $10 per-month premium for categorically needy-optional children in households with incomes between 151% and 200% of federal poverty, to be implemented July 2004 (mandatory children in this income range would not be subject to premiums).

Somewhat simultaneous, the BH program redesigned itself to meet the Legislature's mandate of an 18% reduction[11] and in January 2004 implemented a much changed benefit design. In addition to increases in premium-sharing and co-payments, with which BH enrollees were familiar, enrollees would also face deductibles, co-insurance, and out-of-pocket maximums, all new aspects of the BH design. There was significant concern about the impact of these changes on enrollees and the ability of the program to continue to serve its target population of low-income residents (at and below 200% federal poverty).

Process: In mid-2003 a small policy and research group began meeting to discuss options for a joint Medicaid-BH evaluation of the impacts of premium & cost-sharing changes. Of particular concern was the impact on families that cut across both programs. Because of timing issues and differences in accountabilities (e.g., Medicaid to CMS[12]) the programs elected a dual path: *coordinated* work on routine monitoring of the impacts of the changes on the programs (e.g.,

[8] Premiums for optional children at 151% - 200% federal poverty were delayed – this is a group that never before has had premium contributions. The increase in SCHIP premium sharing went ahead as scheduled in July 04.
[9] SPG staff will participate in a panel discussion on preliminary results at the 11th Annual Washington State Joint Conference on Health, October 2004.
[10] Basic Health is a state-only funded program for low-income working. It contracts with private health plans and provides subsidized coverage, using an income-based sliding scale, to people at and below 200% of federal poverty, not eligible for Medicare, and not institutionalized at the time of enrollment. (There are a few nuances to these eligibility rules, such as for homecare workers, but the above cover the main criteria.)
[11] The Legislature's specific directive was to reduce by 18% the actuarial value of the Basic Health design.
[12] CMS = Centers for Medicare and Medicaid Studies, the federal agency within the Department of Health and Human Services that oversees the joint federal-state Medicaid program.

make-up of the risk pools) and enrollees (e.g., surveys of program participants) and *joint* assessment of the impacts on the external delivery system (e.g., impacts on hospital emergency departments and community clinic operations).

Because BH changes were implemented in January 2004, the program was somewhat ahead of Medicaid in its need to monitor and assess the impacts of the changes. So while the programs worked on the joint assessment piece (impacts on the broader delivery system) and on developing an evaluation design for Medicaid that would meet CMS guidelines, BH moved forward on assessing its program changes. The evaluation design for Medicaid was submitted to CMS in April 2004, assuming a July 2004 implementation of premium-sharing. However, the Governor's decision to delay implementation of children's premiums until at least July 2005 has lessened the "of-the-moment" nature of moving forward on the evaluation (from the perspective of both CMS and the state).

Therefore, the rest of this section focuses on the efforts of BH to assess the impacts of its program changes on low-income working and highlights those elements where the SPG has been most involved.

Methodology: Summaries of the changes to BH are given in Figures 4-4 (cost-sharing) and 4-5 (premium-sharing). The evaluation that is underway includes monitoring changes in enrollment levels (via administrative data), changes in characteristics of enrollees and the aggregate pool (via claims data from health plans), and impacts on enrollees and their families (via surveys).

The SPG program has primarily been involved in assisting BH and its contractor to design the enrollee survey and analyze its results. The survey was fielded in May-June 2004. Its primary purpose was to understand why people who left the program (Leavers) and those who stayed in the program (Stayers) made the decisions they did, and the role that the premium and cost-sharing changes had in those decisions. In addition to understanding the drivers of their decisions we were also interested in what happened to the Leavers (e.g., do they have coverage) and in better understanding the "tipping points" for the Stayers (e.g., what types of future program changes would be hardest on them and perhaps cause them to reconsider the decision to stay in the program). A summary of the survey content is given in Figure 4-6.

Findings/Lessons: Although it's premature to discuss the results in detail, there are a couple of things worth noting at this point.

Regarding findings:

- Preliminarily it seems there is something in the survey results for everyone – no matter what your pre-conceived position on the impacts of the premium and cost-sharing changes you can find something in the data to support it. This is often the case with first-level analyses (e.g., simple frequencies) of complex topics.
- Taken together, the combined findings of the enrollment, claims, and survey data indicate:
    - There are no changes in program exit rates or risk pool make-up that can be directly linked to the premium and cost-sharing changes.
    - A sizeable portion of people who left the program are uninsured.
    - For those who stayed, the program still is highly valued however there is some indication that the target population is being stressed by the changes (based on answers to questions about delays in getting care, amount of out-of-pocket spending, and skipping other household expenses to pay for insurance and care).

Regarding Lessons:

- Designing questions to adequately capture the "tipping point" of the Stayers (i.e., what additional changes might cause them to leave BH) was challenging. Based on preliminary survey results we didn't achieve our goal as well as we had hoped. We tried a series of trade-off questions balancing premium increases, increases in out-of-pocket costs, and reductions in benefits. Hopefully, a thorough analysis of the results and some follow-up focus groups will improve future efforts in this area.
- Timing of the evaluation is an issue and may play out differently in the separate components of the evaluation. For example, given the design of the claims analysis it is likely to reflect impacts of premium changes rather than other cost-sharing changes. The survey, having been fielded in May-June, may have a better chance at capturing some of the impacts of both types of changes – at initial decision time for both Leavers and Stayers and later on for the Stayers as they get more experience with the consequences of deductibles and co-insurance.
- Connecting events that occur in the same time and space can be useful for supporting a point of view but simply be wrong. For example, there is already a tendency by some to link decreases in BH enrollment to the premium and cost-sharing changes when in fact the decreases occurred because of pre-determined caps on enrollment (i.e., the 2003 Legislature directed BH to get enrollment down to 103,000 by December 2003 and then to maintain an average enrollment in 2004 of 100,000).

D. Rural and Safety Net Access, and Uncompensated Care

Our initial grant research included a review of the safety net in Washington, as well as assessment of options for expanding access via the safety net.[13] That work paired with the gradual erosion of our public insurance programs over the last two biennia evolved into a series of incremental efforts to 'stem the tide' and maintain access where possible, and a parallel review of the capacity of the safety net to respond to losses of public insurance coverage.

The availability of new research and monitoring tools assisted our initial efforts to assess the health viability of our safety net. The new set of Safety Net Monitoring Tools from the federal Agency for Healthcare Research and Quality (AHRQ) paired with the Community Tracking Study[14] results for Washington and other states, helped us to objectively confirm that Washington has had a relatively strong safety net compared to many states, at least while economic times were good and uninsurance rates were declining.

More recently as hospitals and community health centers began predicting dramatic increases in uninsured patients, our assessment activities evolved into a more focused review of uncompensated care provided by community hospitals and community health centers, and the intricate link with public insurance and financing programs. The resulting briefing paper is discussed below and, along with a HRSA presentation on this topic, is available on our web site at http://www.ofm.wa.gov/accesshealth/accesshealth.htm.

[13] Washington State Planning Grant, *Targeting the Uninsured in Washington State: Chapter 7 – The Role of the Safety Net; Policy Options Overview and Conclusions, and Research Paper: Direct Provider Subsidies for Safety Net or Charity Care Services.* April 2002. Available on our website at http://www.ofm.wa.gov/accesshealth/accesshealth.htm

[14] Agency for Healthcare Research and Quality(AHRQ) *Safety Net Profile Tool*. September 2003. Felland, Lesser, Staiti, Katz,and Lichiello. *The Resilience of the Health Care Safety Net*, 1996-2001. Health Services Research 38:1, February 2003.

Public Financing and Uncompensated Care Provided by Washington State Community Hospitals and Community Health Centers. This briefing paper includes a look at ten years of charity care and bad debt experience at the 95 community hospitals licensed in Washington State, using financial data submitted to the state Department of Health. The experience of "safety net clinics" or community health centers is represented by the array of clinics that had grants from the federal Bureau of Primary Health Care (BPHC), in 2001. BPHC awarded grants to 21 organizations in Washington, with 205 clinic sites throughout the state.

Inspired by recent work of Jack Hadley and John Holahan,[15] we completed a parallel assessment of financing for uncompensated care in Washington – identifying a range of financing mechanisms that help support uncompensated care, including the critical role public insurance plays, especially for the community health centers and for most of our hospitals. The community health centers in Washington are slightly more dependent on the fate of public insurance programs than centers nationwide because they have organized as a health insurance plan and have become one of the key Medicaid and Basic Health program service providers (Table 4-1).

Table 4-1: Insurance Status of Community Health Center Patients

BPHC Community Health Centers	Washington State[16]	Nationwide[17]
Patients uninsured	34%	39%
Patients insured by Medicaid/SCHIP	40%	36%
Other Public insurance (e.g., Basic Health, Medicare)	15%	9%
Private Insurance	11%	15%

We summarized the key financing mechanisms that help support uncompensated care, and 2001 funding levels, to help policy makers see the complex and disconnected funding streams (available in Table 4-2). Although many of the funding streams are federal, several options are under direct control of state policy makers, and the briefing paper includes recommendations for state policy makers' consideration, including:

- Revisions to our state charity care law;
- Full review of tax expenditures and subsidy payments with application of performance and accountability expectations (e.g., Washington state has allowed a property tax exemption for hospitals since 1886, longer than we have been a state, however there is no explicit performance agreement with the state in exchange for this 'expenditure');
- Renewed state policy dialogue on our commitment to ensuring uninsured have access to care, and the policy and budget tradeoffs of investing in insurance programs vs. subsidies for uncompensated care.

[15] Jack Hadley and John Holahan, *How Much Medical Care Do The Uninsured Use, and Who Pays For It*? February 2003. Health Affairs. Institute of Medicine. Hadley and Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* May 2004. The Kaiser Commission on Medicaid and the Uninsured.

[16] Bureau of Primary Health Care: State Summary for Washington for 2001. Users by Socioeconomic Characteristics.

[17] Sara Rosenbaum, Peter Shin, Julie Darnell. *Economic Stress and the Safety Net: A Health Center Update*. June 2004. Kaiser Commission on Medicaid and the Uninsured.

With respect to this last recommendation, the Brief reminds policy makers that

- Insurance investments are more effective at increasing access to care among low-income populations;
- Investments in insurance may be more effective at reducing emergency room use than an equal investment in subsidy payments to Community Health Centers;
- Enrollment in public insurance coverage can significantly reduce hospital uncompensated care and free up financing currently directed at subsidizing uncompensated care.

Table 4-2.

Financing Mechanisms and Examples in Washington State

Financing Mechanism and Origin of $	*Washington State Examples for 2001 (Aggregate statewide budget figures, sources not available to all facilities)*
Medicare (Federal) **and Medicaid** (Federal and State) • Disproportionate Share Hospital Payments (DSH) – payment adjustment for large numbers of Medicare and Medicaid patients. • Upper Payment Limit (UPL) programs - supplemental payments for some hospitals and nursing homes • Indirect Medical Education (IME) adjustment for teaching costs related to graduate medical education (GME) • Cost-Based Reimbursements for qualified hospitals and clinics	**Medicaid Examples:**[18] • DSH: $42.2 million in payments to hospitals • UPL: $9.2 million in flat payments to Hospital-based nursing homes (known as ProShare payments; not directly linked to uninsured) • IME/GME: $8.3 million to two hospitals with graduate teaching programs • Medicaid Cost-Based Reimbursement payment adjustments of $5.6 million for Critical Access Hospitals and approximately $65 million for Federally Qualified Health Centers
State and Local Payments • Indigent care programs • Trauma Care Payments • Uncompensated care pools	**Example of State Funded Indigent Program:**[19] • Medical Assistance Medically Indigent Program: $33.6 million payments to 33 hospitals in 2001 *Program eliminated by 2003 Legislature, partially replaced with hospital DSH grants for rural and urban hospitals* • Trauma Care Payments (DOH program linked to trauma care for the uninsured.) • Medicaid Hospital Trauma Payments: Payments of $24 million to hospitals for trauma care exclusively for Medicaid patients.
Tax Appropriations (State and Local) Tax income appropriated directly or through exemptions	**Examples of Washington Tax Exemptions:** [20] • Hospital property tax exemptions: $32 million in 2001 (state $7.33 million; local $24.69 million) • Hospital laundry services – sales tax exemption $139,000 in 2001 • Hospital business and occupations tax exemptions on revenues from public programs (Medicare, Medicaid, Basic Health) – estimated at $20 million **Examples of Washington direct tax appropriations:** $50 million in tax revenues in 2001 (41local public hospital taxing districts) [21]
Direct Grants for Care (Federal, State and Local) Federal examples: Bureau of Primary Health Care; National Health Service Corps; Maternal and Child Health Bureau; Indian Health Service; Department of Veterans Affairs; HIV/AIDS;	*Direct Grants for Care – State example* • **State** grants for medical and dental services through Community Health Services grants to clinics of $6 million in 2001 to 29 clinics with 120 sites. [22] *(Grants were increased $2.5 million, 25%, in FY04)*

[18] Washington State Medical Assistance Administration Hospital Analysis for Calendar Year 2001
[19] Washington State Medical Assistance Administration Medically Indigent Program Payments to Hospitals for 2001
[20] Washington State Department of Revenue, Summary of Tax Exemptions for Washington Non-Profit Hospitals cy2001. (Representing approximately 69 non-profit hospitals)
[21] Washington State Department of Health hospital financial reports, and Association of Washington Public Hospital Districts
[22] Washington State Health Care Authority, Community Health Services grant program.

Minnesota Study Replication

In 2003-2004 we also explored the opportunity to replicate a recent University of Minnesota SHADAC study on hospital uncompensated care.[23] SHADAC's study demonstrated that enrollment in public insurance coverage in Minnesota significantly reduced hospital uncompensated care. This finding seemed particularly relevant to policy and budget discussions in Washington, and the recent budget and coverage cuts in our public coverage programs, as described in the executive summary. Responding to state policy makers' interests in locally grounded research and state specific data, we explored the opportunity to replicate the SHADAC study for Washington's public insurance programs.

We provided SHADAC with historical enrollment by county for Medicaid and Basic Health programs, and statewide hospital data, so that they could assess the feasibility of replicating the Minnesota study for Washington. Unfortunately, they found our historical data inadequate to demonstrate a precise relationship, and we were unable to pursue study replication.[24] We have nonetheless successfully incorporated key findings of SHADAC's research into discussions about budget and policy tradeoffs.

Other Rural and Safety Net Access Activities

As mentioned earlier, the grant also supported a series of incremental efforts to 'stem the tide' and maintain access where possible. In addition to efforts briefly described in earlier sections, grant staff researched and developed recommendations for the Governor's rural health 2004 budget package, aimed at supporting rural health infrastructure. The Governor's proposal included expansion of the loan and scholarship program for health professions, expansion of support to assist volunteer retired providers, expansions to assist rural hospitals with a telehealth network, and expanded support for the school nurse corps to ensure sick children in mostly rural school districts had access to minimal health care. While not all proposals were funded by the final Legislative budget, most were, along with expanded state support for community health centers (25% increase), a new family planning outreach pilot in a rural, heavily Hispanic, community, and the 'buy-down' of the proposed premium amounts for children enrolled in Medicaid

In addition to incremental budget investments in rural access, grant staff supported discussion of key policy changes focused on rural access that were presented to, and passed by, the 2004 Legislature, including bills to:

- Expand liability protections for providers volunteering at community health care settings;
- Assist retired providers with malpractice insurance;
- Assist Critical Access Hospitals with the regulatory burden associated with certificate of need and 'swing beds'.

E. On-Going Administrative Simplification Efforts

During the initial grant we included research on system affordability and an assessment of administrative simplification efforts of primary interest to the private sector, in an effort to cooperatively reduce the administrative costs of health care.[25] The hypothesis is that

[23] Lynn Blewett, Gestur Davidson, Margaret E. Brown, and Roland Maude-Griffin. University of Minnesota, State Health Access Data Assistance Center. *Hospital Provision of Uncompensated Care and Public Program Enrollment*. Medical Care Research and Review, December 2003.

[24] A copy of their assessment is available in the Appendix and on our web site at http://www.ofm.wa.gov/accesshealth/accesshealth.htm

[25] State Planning Grant, *Administrative Simplification: An Overview of Selected Administrative Simplification Initiatives and Potential State Actions for Support.* April 2002. Available on our web site.

simplification of the system will (1) reduce inefficiencies and redundancies, and thus contribute to slowing overall cost growth trends and (2) reduce the "hassle factor" for plans and providers, increasing the likelihood that they will continue to 'play' in Washington's market.

The initial research recommendations from a consortium of private sector insurance carriers, hospitals, and providers, known as the Healthcare Forum, caught the interest of legislative policy makers and the executive branch. Subsequently, the activities of the Healthcare Forum have expanded to include a partnership with three state agency insurance programs (state employees, Medicaid, and injured workers).

The broad consortium has now developed twenty-two policy changes concentrated in three main areas: claims payments processes, referral processes, and credentialing processes.[26] These changes will move the industry toward standardization in key business practices and save time and money across the system, as well as decrease the hassle between providers and health plans. There is an estimated 226 hours of weekly savings in staff hours (156.5 for health plans, 44 for hospitals, and 25.5 for providers) from these policy changes alone. Examples of the changes include agreements from all participants (business competitors) to use standardized forms for submitting supporting claims documentation, corrected claims, standard referral actions, and requests for prospective review. This project now has a life of its own outside the SPG and continues to hold the interest of legislative policy makers, as demonstrated by two legislative hearings in September and anticipated legislative discussions in December.

An additional administrative simplification effort continued our work, albeit in a slightly different direction. With the assistance of SPG staff, the Governor sponsored a broad private-public task force to focus on hospital administrative burdens. The task force of eight executive branch agencies,[27] the Washington State Hospital Association, and member hospitals focused on identifying opportunities to streamline the regulatory burdens associated with on-site hospital inspections, and the potential overlap of responsibilities of these multiple agencies. The task force identified recommendations in three main areas – patient care related inspections, fiscal and tax inspections, and facility or physical plant inspections.

Legislation capturing key recommendations was introduced and passed in the 2004 Legislative session[28], and coordination efforts expanded beyond the state agencies to include local government inspections (e.g., coordination with the state fire marshal and local building or fire agencies), and where possible, coordination with the Joint Commission on Accreditation of Health Care Organizations (JCAHCO). Progress continues to be made with pilot sites, and a formal progress report to the Legislature is due in December 2004.

[26] A complete list of the 22 policy changes can be found on the Healthcare Forum's web site at www.wahealthcareforum.org.
[27] The range of agencies with regulatory authority include: the State Auditor's Office, the Department of Revenue, the Department of Social and Health Services, the Department of Health, the State Board of Pharmacy, the Department of Ecology, the Office of the State Fire Marshal, and the Department of Labor and Industries.
[28] Senate Bill 6485, Improving the Regulatory Environment for Hospitals

Figure 4-1: State Policy Activities Most Directly Aligned with the Federal State Planning Grant Program Goal Of "Covering The Uninsured"

COVERAGE STRATEGY	✓ = Passed	2003-04 PROPOSED AND/ OR PASSED LEGISLATION MOST DIRECTLY RELATED TO ACCESS TO HEALTH INSURANCE COVERAGE
Cover All Kids		**(HB 3184) Study and recommendations on health insurance coverage for children.** Declares *intent* to provide access to health insurance for all children in Washington by 2008 by building upon and strengthening employer-sponsored coverage and publicly supported children's health insurance programs. Requires a *study* and recommendations on possible approaches; due to the Governor and Legislature by December 1, 2004.
Small Employer Assistance	✓	**(ESHB 2460) Health insurance for small employers and their employees.** Changes definition of small employer from 1-50 to 2-50 employees; authorizes limited benefit plans for all small employers; authorizes initial small group rates based on claims costs and rate increases based on benefit design and provider network (up to 4% variation from carrier's entire small group pool); under specific circumstances, ex-employees of employers with < 20 employees can apply for individual coverage without taking the health screen questionnaire required by the individual market; continuity of coverage requirement extended to groups of up to 200 with provisions for when policy can be cancelled. **(HB 3104) Health insurance for employers and their employees.** A provision of this bill (that did not end up in ESHB 2460) was elimination of Washington's "every category of provider" requirement (currently, for all plans subject to state regulation enrollees have the option of seeking treatment from any type of provider as long as the condition is covered by the plan, the treatment is appropriate to the condition, and the provider is acting within scope of practice). This issue was important enough to small business representatives that they proposed an initiative to the people, one provision of which would allow plans with fewer categories of providers; the initiative did not get enough signatures to appear on the November 04 ballot. **(HB 2785) Access to health insurance coverage.** See description under Large Employer Incentives **(HB 2798) Stabilizing the health insurance market and providing coverage for the uninsured.** See description under Private Market Access & Affordability.

Figure 4-1: State Policy Activities Most Directly Aligned with the Federal State Planning Grant Program Goal Of "Covering The Uninsured"

COVERAGE STRATEGY	✓ = Passed	2003-04 PROPOSED AND/ OR PASSED LEGISLATION MOST DIRECTLY RELATED TO ACCESS TO HEALTH INSURANCE COVERAGE
		(SB 6422) Small employers and Basic Health. Would have pooled Basic Health's small employer group enrollees with subsidized enrollees for purposes of rating (independent of whether the employer group enrollees are subsidized or not).
		(HB 2015) Health insurance for small employers and their employees. A unique component of this bill (not appearing in any passed bill) was the requirement that state agencies offering Medicaid and Basic Health collaborate with community and regional health care access efforts to design coverage pilot programs aimed at small employers.
		(HB 2087) Definition of small employer. Would have specifically included self-employed and sole proprietors (often businesses of one) in the definition of small employer in order to assist them in finding affordable health coverage. (In contrast to the bill that passed that excluded groups-of-one from the definition.)
		(SSB 5521) Health insurance for employers and employees. This earlier cousin to the bill that passed (ESHB 2460) included some widely debated provisions that didn't appear in the final bill; these included partial exemption from Washington's "every category of provider" law for bare bones/value plans; a cap on community rating based on age of employee of 500 percent; and use of the health screen for sole proprietors and the self-employed.
Employer Coverage Options & Responsibilities		**(HB 2785) Increasing access to health insurance coverage.** (Washington's version of "Pay or Play") Would impose a fee on large employers (> 50 full time equivalent employees) to be used to purchase health insurance for employees; would authorize Basic Health funds to be used to subsidize employee premium shares for small-employer sponsored health insurance; would allow small employers to enroll as a group in Basic Health and have their costs subsidized.

Figure 4-1: State Policy Activities Most Directly Aligned with the Federal State Planning Grant Program Goal Of "Covering The Uninsured"

COVERAGE STRATEGY	✓ = Passed	2003-04 PROPOSED AND/ OR PASSED LEGISLATION MOST DIRECTLY RELATED TO ACCESS TO HEALTH INSURANCE COVERAGE
		(SHB 3047) Health care services. Would require applicants for state purchased health care benefits (e.g., Medicaid and Basic Health) to identify their employer (originally included applicants for uncompensated hospital care as well).
		(SB 5944) Employers & Basic health. Would require 50/50 premium split between Basic Health enrollees & their employers (employer amount divided among employers for enrollees with more than one employer). Other unique aspects of the bill (not found elsewhere) included increasing the premium tax from 2% to 3% (one of the revenue streams that supports Basic Health) and setting the minimum Basic Health enrollment level at 70,000 (is currently set at 100,000).
		(HB 1830) Public program coverage of employed individuals. Basic Health and Medicaid (Medicaid subsequently deleted) could seek reimbursement from public and private employers if their employees were enrolled in public programs.
		(SB 5704) Employer participation in Basic Health. Would have removed authority of Basic Health to accept applications from employer groups; instead, it would require any employer of a Basic Health enrollee to contribute to the enrollee's premium.
Private Market Access & Affordability	✓	**(SHB 2985) Individual health insurance for retired and disabled public employees.** If unable to offer access to group coverage, political subdivisions must assist their retirees and disabled employees in applying for individual health insurance.
	✓	**(ESSB 6112) Multiple employer welfare arrangements**. Creates consumer protection standards to better ensure financial status and operational competence of MEWA-based health insurance coverage – issue is to ensure that employees who *think* they have reliable coverage through a MEWA, in fact, actually *do have* reliable coverage.

Figure 4-1: State Policy Activities Most Directly Aligned with the Federal State Planning Grant Program Goal Of "Covering The Uninsured"

COVERAGE STRATEGY	✓ = Passed	2003-04 PROPOSED AND/ OR PASSED LEGISLATION MOST DIRECTLY RELATED TO ACCESS TO HEALTH INSURANCE COVERAGE
		(HB 2798) Stabilizing the health insurance market and providing coverage for the uninsured. Would create (1) a Health Insurance Market Stabilization Pool to provide reinsurance for enrollees with over $25,000 in annual health services expenses; (2) a small employer-sponsored health insurance premium assistance program for employees whose current employer has not offered health insurance within the last six months; and, (3) a premium assistance program for individuals receiving health services through the Washington State Health Insurance Pool (i.e., high risk pool). (Bill was outgrowth of Washington Insurance Commissioner's – Commissioner Mike Kreidler -- task force on reconstructing the health care market.)
		(HB 2018) High risk pool eligibility. Would open the state's high risk pool to HIPAA-eligibles and people eligible for the Trade Act's federal tax credit *without* first requiring them to take the state's individual market health screen questionnaire (and be rejected for individual coverage and thus referred to the high risk pool). (See ESHB 2797 under Public Program Redesign & Accessibility)
Public Program Redesign & Accessibility	✓	**(ESHB 2797) Health insurance for people eligible for the Federal Health Coverage Tax Credit.** Basic Health now available as a qualified plan for the federal Health Coverage Tax Credit Program (under federal Trade Act of 2002).
	✓	**(SB 6057) Basic health funding.** Amends an initiative passed by the people so that money raised through increased cigarette & tobacco taxes and intended for expansion of Basic Health slots can be used to fund existing enrollees (below the 125,000 base called for in the initiative).
	✓	**(HB 2285) Cost-sharing in public programs.** Authorizes premium and other cost-sharing (e.g., co-payments, deductibles, coinsurance) for enrollees of Medicaid and other state medical assistance programs. (Basic Health already has this authority.)

Figure 4-1: State Policy Activities Most Directly Aligned with the Federal State Planning Grant Program Goal Of "Covering The Uninsured"

COVERAGE STRATEGY	✓ = Passed	2003-04 PROPOSED AND/ OR PASSED LEGISLATION MOST DIRECTLY RELATED TO ACCESS TO HEALTH INSURANCE COVERAGE
	✓	**(EHB 1777) Homecare worker coverage**. Via collective bargaining between the state and individual home care workers hired by the state (but not considered state employees), the state pays the majority of the premium for workers eligible for Basic Health coverage. A provision for the state to contribute $400 per month per homecare worker for health care benefits through a Taft-Hartley trust was not passed.
	✓	**2003 Biennial and 2004 Supplemental Budgets** • Medically indigent program changed from open-ended entitlement program to 2 capped grant programs (one for rural hospitals, another for all other hospitals). • 2003 budget set premiums for (optional) children's medical coverage in Medicaid and SCHIP, effective Feb 04. 2004 supplemental revised the premium amounts and moved start date -- children's premiums set at $10 if 151% - 200% federal poverty & $15 if 201% - 250% federal poverty, effective July 04. Governor's administrative action delayed implementation until at least July 05 for children 151%-200%. • Use of SCHIP money to cover about 65% of cost of pre-natal coverage for low-income, immigrant women not eligible for Medicaid. • Increase income verification requirements in Medicaid & Basic Health. • In medical assistance, reduce scope of adult dental coverage & expenditures on adult durable medical (DME) equipment; require co-payments for adult DME & optical services. • Limit Basic Health enrollment to 103,000 by Dec 03; after Dec 03 maintain average enrollment at 100,000. • Implement by Jan 04 Basic Health premium, benefit & cost-sharing changes to reduce state costs of covered services by 18%. • Increase cost-sharing in the AIDS prescription drug assistance program (from 2-4% to 5-10% of family income). • Study costs/benefits of K-12 bargaining units purchasing coverage through public employees' benefits program.
		(SB 5944) Employers & Basic health. See description under Employer Coverage Options & Responsibilities.
		(SB 5704) Employer participation in Basic Health. See description under Employer Coverage Options & Responsibilities.

Figure 4-1: State Policy Activities Most Directly Aligned with the Federal State Planning Grant Program Goal Of "Covering The Uninsured"

COVERAGE STRATEGY	✓ = Passed	2003-04 PROPOSED AND/ OR PASSED LEGISLATION MOST DIRECTLY RELATED TO ACCESS TO HEALTH INSURANCE COVERAGE
		(HB 1375) Basic Health eligibility. Would eliminate Basic Health eligibility for full-time students who are on temporary visas to study in US.
		(SHB 2019) Basic Health eligibility. Would allow applicants to be rejected from non-subsidized Basic Health, and referred to the state's high risk pool, based on their health screen questionnaire results (the same questionnaire required by applicants to the individual market).
		(ESSB 5807) Basic Health eligibility. Most notable eligibility changes include (1) restricting Basic Health to citizens and people legally admitted for permanent residence (currently any state resident is eligible); (2) removing provision that allows expansion of subsidized Basic Health from 200% to 250% of federal poverty if funds are available; and, (3) making people ineligible if they qualify for Medicaid. In addition, the Legislature would get directly involved in setting minimum premiums.
		(SB 5998) Community-based demonstrations. Would require state agencies to actively recruit local organizations to operate pilot projects to test different Basic Health eligibility, benefit design, and cost-sharing arrangements (with the expectation that a greater number of people could be covered).
Health System Reform (Coverage Aspects)		**(HCR 4403) Health Care Access Options Working Group**. A working group of stakeholders would be created to make recommendations on improving Washington's health care insurance system to make private coverage more affordable and accessible. (Although this bill did not pass, the Insurance Commissioner created a separate task force to address similar issues. One result was HB 2798 described under Private Market Access & Affordability.)

Figure 4-1: State Policy Activities Most Directly Aligned with the Federal State Planning Grant Program Goal Of "Covering The Uninsured"

COVERAGE STRATEGY	✓ = Passed	2003-04 PROPOSED AND/ OR PASSED LEGISLATION MOST DIRECTLY RELATED TO ACCESS TO HEALTH INSURANCE COVERAGE
		SB 5313: Washington Health Care Recovery. Proposed a number of changes that would have affected access to coverage including requirements for (1) a specific deductible in Basic Health, (2) state agency participation with local organizations to develop alternative Basic Health offerings, and (3) prohibiting additional mandated benefits in the private market pending a study of current mandates.

Notes:

Table contents focus on proposed and/or passed legislation that is most directly related to health insurance coverage. Other strategies indirectly related to coverage, such as shoring up the safety net, access in rural areas, administrative simplification & coordinated state purchasing, additions/deletions of certain benefits (e.g., prescription drugs), and medical malpractice are not included.

In addition, the intent is to capture the provisions in the bills that are most directly related to insurance coverage – bills may contain other provisions.

Finally, for some issues many similar bills are initially introduced (small employer / small group market is a good example). In the case of bills that did not pass, not all coverage-related provisions are noted; highlighted are those provisions that generally did not make it into final bills and that spurred debate.

Figure 4-2: Examples of Activities Related to Potential Policy Options for Enhancing Access to Health Insurance

Major Grouping[i]	Specific Options Addressed in Initial SPG Research	Examples of Related Activities Affecting Coverage in WA State 2003 – 2004
I. Financial incentives to individuals and families to purchase health insurance (Subsidies include vouchers, tax credits, and direct payments)	**Subsidies to assist low income in buying individual coverage**	Basic Health and Medicaid 2004 program changes (see section VI below)
	Subsidies to assist high-risk people in buying individual coverage (state high risk pool)	2003 and 2004 Legislative discussions explored options for modifying the high risk pool and becoming federally qualified.
	Subsidies or reforms for transitional coverage (e.g. COBRA)	• Awareness campaign to alert eligibles re federal income tax credit through Trade Adjustment Act (TAA); state labor department request to expand tax credit • 2004 statutory approval for Basic Health to become a "qualified plan" under the TAA Health Coverage Tax Credit program. Enrollment growing.
	Subsidies of employee contributions to employer-sponsored insurance (premium assistance programs)	Medicaid program small but still functioning; CMS discussions on expansion.
II. Financial incentives to employers to purchase health insurance for their employees	• Direct subsidies or tax credits to employers • Play or pay mandate on employers	• 3- and 4-part contribution options for small employers being explored by community groups • 2003 and 2004 legislative discussions re various "pay or play" requirements for employers
III. Health insurance purchasing pools	• Employer-based purchasing pools • Individual or individual/small market purchasing pools • Other community-based purchasing pools • Mobile worker purchaser pools • Consolidated state funded pools	• Safe Table (educational) forums on employer coverage options and pooling opportunities • "Local purchasing utility" idea being explored by community group as means of pooling financing (inspired by SPG-SCI community-based coverage & purchasing pool technical assistance meeting) • 2003 statutory approval for low-income seniors to participate in consolidated drug purchasing program for state agencies.

Figure 4-2: Examples of Activities Related to Potential Policy Options for Enhancing Access to Health Insurance

Major Grouping[i]	Specific Options Addressed in Initial SPG Research	Examples of Related Activities Affecting Coverage in WA State 2003 – 2004
		• 2004 statutory authorization for collective bargaining agreement for independent home care workers, including health coverage. Taft-Hartley trust option being pursued by union/ Home Care Quality Authority. • Private Fortune 500 companies (including WA-based Starbucks) spearheading collaborative to cover retirees, part time employees & other special populations • Washington Artists Health Insurance Project to improve access to coverage for people in the arts and arts-related occupations
IV. Insurance market regulations	• Relief from benefit mandates • Individual and small-group market regulations • High-risk pool expansion • **Universal catastrophic coverage**	• 2004 Legislative reforms for small employer groups – redefined group size as 2-50, community rating range increased, some benefit mandate relief. Continuing interest in 2005 ballot initiative to further refine benefit mandates and rate adjustments. • Subsidies not changed but health screening questionnaire revised in June 2003 to screen additional people out of individual market and into high risk pool (about 20% of those referred to pool enroll; some get coverage elsewhere; many forgo any coverage) • 2003 statutory limit placed on number of subsidized "HIV Insurance Program" people that can be enrolled in high risk pool. • 2003 legislative discussion re Washington high risk pool becoming "qualified" under TAA – concern by small business & carriers about any action that would expand high risk pool access – legislation didn't move. See section I above re Basic Health TAA qualified status. • Interest in universal catastrophic coverage (coupled with individual mandate) by Insurance Commissioner, included in "Let's Get Washington Covered" task force discussions.

Figure 4-2: Examples of Activities Related to Potential Policy Options for Enhancing Access to Health Insurance

Major Grouping[i]	Specific Options Addressed in Initial SPG Research	Examples of Related Activities Affecting Coverage in WA State 2003 – 2004
V. Direct subsidies for safety net or charity care services (for those whom insurance may never seem like a viable option)	• **Expand state's Community Health Services grant program** • **Create discount health cards for individuals** • **Expand federal health professional shortage areas (HPSAs)** • **Expedite Rural Health Center designation** • Increase payment to providers via health plan contracts • Tax credit for not-for-profit hospitals • Tax credit for physicians, physician assistants, and nurse practitioners • Uncompensated care pools	• Expansion of direct grant program to migrant and community health clinics included in Governor's 2003-05 budget (eliminated in final budget negotiations); funded in 2004 supplemental • Priority of community coverage initiative is to stabilize safety net by expanding number of community health centers & rural clinics • Use of discount cards for low-income uninsured being used by community group in central WA • Modest expansion of designated HPSA areas • Governor's 2004 rural budget package with investments in rural infrastructure, increase in health professional loan program and state paid med-mal insurance for retired providers to expand access in rural communities • 2004 legislation offering medical malpractice protection for providers serving in clinics as volunteers • Modifications in DSH payments to "compensate" for elimination of Medically Indigent program in Medicaid
VI. Public Insurance Program Expansions	• Although options re public insurance programs are part of our SPG work, our initial background research did not include a review of detailed options. Washington has been a leader in the three areas most commonly discussed, i.e., (1) attain full enrollment of all currently eligible individuals into existing public programs, (2) expand eligibility for children by raising the income eligibility level, and (3) extend coverage for adults – first focusing	• BH cost-sharing changes for 2004 including introduction of deductibles, increased co-pays and premium share, and reduction of enrollment slots to 100,000 from 130,000 • Elimination of state funded Medically Indigent program in Medicaid • Medicaid children premium sharing for 2004 (2003 statutory approval for cost-sharing in Medicaid, 2004 waiver accepted by CMS; Governor Locke delayed implementation until July 2005) • Expansion of SCHIP coverage for pregnant women • Local initiative to develop consumer-driven, incentive-based

Figure 4-2: Examples of Activities Related to Potential Policy Options for Enhancing Access to Health Insurance

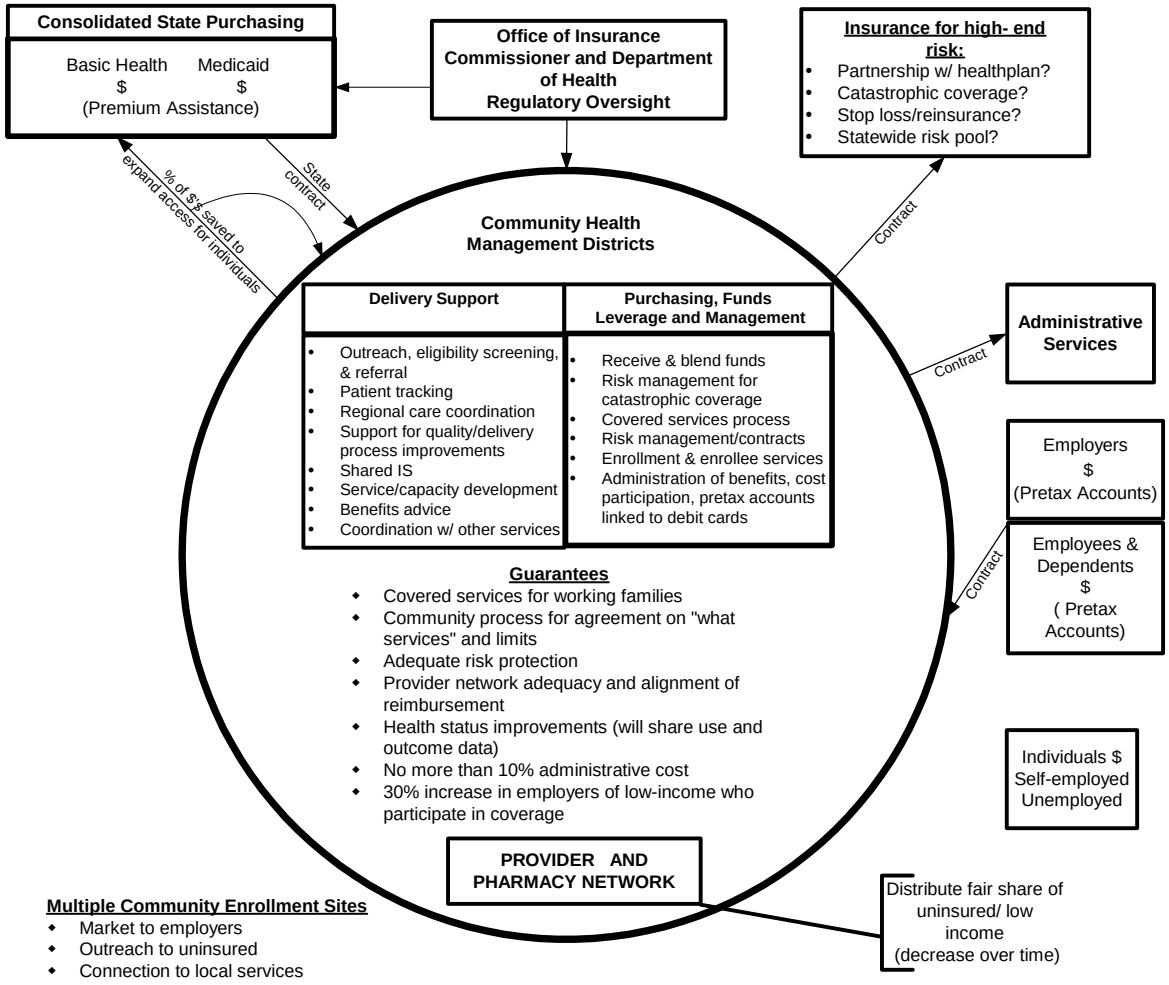
Major Grouping[i]	Specific Options Addressed in Initial SPG Research	Examples of Related Activities Affecting Coverage in WA State 2003 – 2004
	on parents of eligible children and then on adults without children.	coverage option (health reimbursement account + proven preventive care) to potentially pilot in a public program (Health Plan for Life) • Statutory request to find cost savings in local government procurement of health insurance for home care worker agencies
VII. Other (including Administrative Simplification)		• 2003 statutory requirement for uniform administrative, purchasing & quality policies across state programs • Public / private partnership among state agencies, hospitals, and private consortium of insurance carriers to reduce administrative burdens and increase efficiency. • Foundation sponsored community roundtables, dialogues and surveys to identify values of Washington residents vis-à-vis access & coverage to care • Community initiatives to use access to medical homes and preventive care as entrée to access to insurance coverage • ONEHEALTHPORT developed secure digital portal for efficient processing of medical records – collaboration of private insurance carriers and health care providers. Current efforts targeting the development of a secure medical records sharing platform.

[i] See *"Potential Policy Options for Enhancing Access to Health Insurance Coverage in Washington State"*, available at: http://www.ofm.wa.gov/accesshealth/accesshealth.htm

Bolding indicates options identified in initial research as "most promising" based on these criteria: (1) effectiveness in insuring high risk people, (2) effectiveness in insuring low-income people, (3) effectiveness in improving access to health services for the uninsured, (4) benefit per dollar of new state spending, (5) cost to the state, and (6) implementation feasibility.

Figure 4-3:

Community Health Management District: Schematic with Illustrative Guarantees



Source:

Community-Based Health Care, Issue Paper Draft #3, Communities Connect, available from CHOICE Regional Health Network, Community Health Works program.

Figure 4-4: Major Cost-Sharing Changes in Basic Health Benefit Design, 2003 to 2004

Cost-Sharing	2003	2004
Deductible and co-insurance	None	$150 per person per year; 80/20 co-insurance
Out-of-pocket maximum	None	$1500 per person per year
Office Visit Co-pay	$10	$15
Share of prescription drug costs	3 Tiers: T1: $3 on specific drugs such as prenatal vitamins & insulin T2: $7 on generics in health plan's formulary (except if in Tier 1) T3: 50% co-insurance on all other drugs (e.g., brand name) in plan's formulary	2 Tiers: T1: $10 co-pay on generics in health plan's formulary; T2: 50% co-insurance on all other drugs (e.g., brand name) in plan's formulary

Figure 4-5: Basic Health Enrollee Premium Share, 2003 and 2004, By Income Band, For a 40-54 Year Old in the Benchmark Plan

Income Band (% of federal poverty)	2003	2004
< 65 %	$10.00	$17.00
65% - < 100%	$14.00	$22.50
100% - < 125%	$17.50	$30.00
125% - <140%	$30.15	$39.47
140% - < 155%	$46.23	$51.57
155% - < 170%	$60.30	$65.72
170% - < 185%	$76.38	$82.29
185% - 200%	$92.46	$100.91

70+ percent of enrollees are in families with incomes below 125% of poverty

Benchmark Plan: Typically the lowest priced plan in an area.
'03 Benchmark Plan rate = $201.36
'04 Benchmark Plan rate = $184.05

Basic Health is age-rated with older adults paying more per month than younger. There are four adult age groups: 0-39, 40-54, 55-64, and 65+. The 40-54 year old group, used in this table, typically accounts for around 35-40 percent of adult enrollment.

One perspective on the magnitude of these changes for a low-income person is this: Between 2003 and 2004, a 40-54 year old in the benchmark plan with income at 100% federal poverty had a 70 percent increase in the amount of his/her income that had to be set aside for premium. (In 2003, 2.3% of income went to premium; in 2004, 3.9% went to premium.)

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

ITEMS APPEARING ONLY ON LEAVER VERSION

Cost-Sharing and Coverage

No.	Question Summary	Response Format	Comment
2a-2m	Reasons for not currently being in BH 2a Got coverage thru another source 2b Couldn't afford BH 2c If need care, can get it free or at low cost from local providers 2d Need services not covered by BH 2e Decided don't need coverage now because don't get sick 2f More important to spend what have on insurance or care for other family members 2g More important to spend what have on other household expenses or bills 2h Desired health plan or providers are not longer available in BH 2i Income increased so no longer eligible 2j Found a health plan that's a better value 2k Didn't get monthly premium in on time 2l Requirements & paperwork are too much of a hassle 2m Some other reason not mentioned	Yes, No, Don't Know, Refused To each of the 13 items	
2n	"Other" reasons for not being in BH	Open-ended	Asked if "yes" to 2m
2o	Most important reason for leaving BH	Pick one of 2a-2n	Asked if "yes" to > 1 of 2a-2n "Most important" inferred if "yes" to only one of 2a-2n
3a	Aware of cost-sharing changes to BH	Yes, No, Not sure, Refused	
3b	Amount of influence cost-sharing changes (collectively) had on decision to leave BH	A lot, A little, Nothing, Don't know, Refused	Asked if 3a = yes, don't know, or refused

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

No.	Question Summary	Response Format	Comment
3c1-3c5	Level of influence of each cost-sharing change (separately) on leaving BH 3c1 Change in monthly premium 3c2 Increase in office visit co-pay from $10 to $15 3c3 Increase in share of prescription drug costs 3c4 Introduction of annual $150 deductible 3c5 Introduction of $1500 out-of-pocket maximum per year	Rate each of the five changes on scale of 1 (no effect) to 5 (major effect), Don't know, Refused	Analyze individually & collectively Asked if 3b = A lot, A little, Don't know
3d	Most important influence on leaving BH	Pick one of 3c1-3c5	Asked if highest score given to > 1 of 3c1-3c5 Most important inferred if highest score to only one of 3c1-3c5
4a	Have health coverage now (for self only)	Yes, No, Don't know, Refused	
4b	How get that coverage (from where)	Open-ended: Following used for coding & if person unsure are read as prompts: Your employer, Your spouse's or partner's employer, Through COBRA, Through your parents or another family member, Military coverage (e.g., Champus or TriCare), A plan you purchase directly & pay for on own, Medicaid or Healthy Options, Through school, Medicare, Indian Health Services	Asked if 4a = yes
4c	Current coverage compared to BH	Better than, Worse than, About the same as, Don't know, Refused	Asked if 4a = yes
4d	Reason why coverage is (better, worse, same as) BH	Open-ended	Asked if 4c = better, worse, or same as

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

ITEMS APPEARING ONLY ON STAYER VERSION

Cost-Sharing and Coverage

No.	Question Summary	Response Format	Comment
2	Aware of cost-sharing changes to BH	Yes, No, Not sure, Refused	
3a-3m	Importance of reasons for staying in BH 3a Too much hassle to look for other coverage 3b BH is still best value 3c Would have to pay more per month if not in BH 3d Someone helps pay BH monthly premium 3e No other insurance choices are affordable 3f Can have same health plan as children 3g Can keep BH even if change jobs 3h Can get preventive care like shots & routine exams without paying anything at doctor's office 3i Like that BH is sponsored by state government 3j No other insurance choices cover services that are needed 3k Afraid couldn't get back in BH if leave 3l In middle of treatment for an illness or injury & can't risk interruption in care 3m Some other reason, for staying, not mentioned	Rate each of 3a through 3l on scale of 1 (not at all important) to 5 (very important), Don't know, Refused 3m: Yes, No, Don't know, Refused	
3n	"Other" reason for staying in BH	Rate on scale of 1 (not at all important) to 5 (very important), Don't know, Refused	Asked if 3m= yes
3o	Most important reason for staying in BH	Pick one of 3a-3n	Asked if highest score given to > 1 of 3a-3n Most important inferred if highest score given to only one of 3a-3n
4a	If trade-off needed, which would be harder – pay higher monthly premium or pay more out-of-pocket when get care	Higher monthly premium, More out-of-pocket, Don't know, Refused	Analyze 4a-4c collectively as set of 3 trade-off questions

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

No.	Question Summary	Response Format	Comment
4b	If trade-off needed, which would be harder – pay higher monthly premium or have some benefits reduced	Higher monthly premium, Reduce benefits, Don't know, Refused	Analyze 4a-4c collectively as set of 3 trade-off questions
4c	If trade-off needed, which would be harder – have some benefits reduced or pay more out-of-pocket when get care	Reduce benefits, More out-of-pocket, Don't know, Refused	Analyze 4a-4c collectively as set of 3 trade-off questions
4d(a)	Have to leave BH if premium increased by $10 / month	Yes, Maybe, No, Don't know, Refused	Asked if "increase premium" selected 2X in 4a-4c
4d(b)	Have to leave BH if premium increased by $5 / month	Yes, Maybe, No, Don't know, Refused	Asked if "increase premium" selected 2X in 4a-4c AND 4d(a) = yes, maybe, don't know, refused
4e(a)	Have to leave BH if deductible increased by $50 / year (making it $200 / year)	Yes, Maybe, No, Don't know, Refused	Asked if "increase OOP" selected 2X in 4a-4c
4e(b)	Have to leave BH if deductible increased by $25 / year (making it $175 / year)	Yes, Maybe, No, Don't know, Refused	Asked if "increase OOP" selected 2X in 4a-4c AND 4e(a) = yes, maybe, don't know, refused
4e(c)	Have to leave BH if Rx co-pay increased by $5 (making it $15)	Yes, Maybe, No, Don't know, Refused	Asked if "increase OOP" selected 2X in 4a-4c
4e(d)	Have to leave BH if Rx co-pay increased by $2 (making it $12)	Yes, Maybe, No, Don't know, Refused	Asked if "increase OOP" selected 2X in 4a-4c AND 4e(c) = yes, maybe, don't know, refused

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

No.	Question Summary	Response Format	Comment
4e(e)	Have to leave BH if office visit co-pay increased by $5 (making it $20)	Yes, Maybe, No, Don't know, Refused	Asked if "increase OOP" selected 2X in 4a-4c
4e(f)	Have to leave if new $15 office visit co-pay for preventive & maternity care added (compared to no co-pay now)	Yes, Maybe, No, Don't know, Refused	Asked if "increase OOP" selected 2X in 4a-4c
4f	Which 1 or 2 benefits, if eliminated, would make you leave BH	Open-ended	Asked if "reduce benefits" selected 2X in 4a-4c

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

ITEMS COMMON TO BOTH LEAVER AND STAYER VERSIONS

Access to Care (for self)

No.	Question Summary	Response Format	Comment
5a	Any time you did not get / delayed getting needed care or Rx since January	Yes, No, Don't know, Refused	
5b	Happen > 1 time	Yes, No, Don't know, Refused	Asked if 5a = yes
5c	(Last time it happened) Main reason for not getting or delaying care / Rx	Open-ended. Following used for coding & if person unsure are read as prompts: Did not have money to pay for it, Could not get appointment as soon as wanted, Could not get care or prescription because already owed money to the doctor, clinic, hospital or pharmacy, Provider would not accept insurance plan, Did not think problem serious enough to pay amount asked, Did not know where to go for help, Takes too long to travel to where help is available, Could not get there when they're open, Did not have childcare, Did not have transportation, Health plan would not pay for needed treatment, Could not find specialist, *Employer* would not give time off from work, *Personally* too hard to find free time because of work & other commitments, Could not afford to take time off from work, Other: _____, Don't know, Refused	Asked if 5a = yes

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

No.	Question Summary	Response Format	Comment
Utilization of Services (for self)			
6	Number of emergency room visits since January	Open-ended. Following used for coding & if person unsure are read as prompts: None, 1, 2-3, 4-5, More than 5, Don't know, Refused	
7	Number of office, clinic, other provider visits since January (include preventive care & care when sick; exclude emergency room visits & overnight hospital stays)	Open-ended. Following used for coding & if person unsure are read as prompts: None, 1, 2-3, 4-5, More than 5, Don't know, Refused	
Financial Impacts (for family)			
8a	Amount of out-of-pocket spending for medical care and Rx since January (self & family) (exclude monthly premiums & dental expenditures)	Less than $100, More than $100, Don't know, Refused	
8b	If more than $100 out of pocket, how much spent	Less than $500, $500 but less than $1000, $1000 but less than $1500, $1500 or more, Don't know, Refused	Asked if 8a = More than $100
9	Since January, had to skip or cut back on paying other bills or household expenses to pay for health insurance, medical care or Rx for self or family	Yes, No, Don't know, Refused	
Health Status & Chronic Conditions (for self)			
10a	Rate own health	Excellent, very good, good, fair, poor, Don't know, Refused	
10b	Rate current health compared to one year ago	Much better now, Somewhat better now, About the same, Somewhat worse now, Much worse now	

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

No.	Question Summary	Response Format	Comment
11a-11k	Have any of these chronic conditions 11a Asthma 11b Diabetes or sugar diabetes 11c High blood pressure or hypertension 11d Depression, anxiety, or other mental health condition 11e Heart problems 11f Physical disability 11g Lung disease 11h High cholesterol 11i Cancer 11j Serious headaches or backaches 11k Other _____	Yes, No, Don't know, Refused To each of the 10 listed conditions plus "other" option	
Household Make-up & Coverage Impacts			
12a	Number of children (< age 19) living in household	Open-ended	
12b	Any children in state coverage programs	Yes, No, Don't know, Refused	Asked if 12a > 0
12c	Continue coverage of child(ren) if new or additional premiums of $5-$10 per month per child	Open-ended. Coded to following: Yes, because no other choice Yes, for some but not all children Yes, any other reason or no reason given No Don't Know, Refused	Asked if 12b = yes
12d	Drop own coverage if new or higher premiums of $5-$10 per child	Yes, No, Don't know, Refused	Asked if 12c = yes, don't know, refused
Demographics (self)			
13	Current employment situation	Work in own business, Work for someone else in full-time job, Work for someone else in one or more part-time jobs, Other _____, Don't know, Refused	

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

No.	Question Summary	Response Format	Comment
14	Full-time student	Yes, No, Don't know, Refused	
15	Race/Ethnicity	Open-ended. Following used for coding & if person unsure are read as prompts: Black or African-American, White (Caucasian), Eskimo or Aleut or Alaska Native, American Indian or Native American, Asian American or Pacific Islander Hispanic or Latin American (e.g., Mexican, Puerto Rican, Cuban, Latino), Other or mixed background: _____, Don't know, Refused	

Notes:
Exact wording of questions and response options is paraphrased in above table.

Additional demographics from administrative/enrollment records include: Basic Health income band, primary language spoken, geographic location (county / zip), gender, date of birth, enrollment history.

Unless otherwise noted "cost-sharing" refers to both premium sharing and other types of cost-sharing such as deductibles, co-payments, coinsurance, and out-of-pocket maximums.

SECTION 5. CONSENSUS BUILDING STRATEGIES:

Our communication strategy reflects a long-standing belief that has underpinned the SPG program – consensus building on coverage strategies in Washington will occur over the long run through political processes fed by the grant but not pushed by the grant. Our communication plan is built around the **theme** of "sustaining awareness" of the individual and societal problems associated with less-than-full coverage of our population. Overall, our **strategy** is best described as low-key, personal, and under-the-radar. An **underlying philosophy** has been to stay relevant to the environment and discussions as they change and occur within varied audiences.

Our strategy has several **objectives**: (1) to function as a clearinghouse of information and visible point of contact within the executive policy office, (2) to encourage and support (but rarely endorse) any group, organization, or individual that is willing to think creatively about addressing coverage and access issues, and 3) to "create" demand for our research work as an objective foundation for discussions and planning, and to respond to existing needs for information. We purposefully elected to exclude "selling a specific set of coverage options" as an objective.

Avenues we use to communicate include (1) a SPG-specific website containing all of our research results, (2) "fast facts" two-page briefs, (3) presentations to small groups (some of which we contact; others of which contact us), (4) assistance to groups and individuals in tailoring our information to their needs, and (5) personal participation in state and community groups with related interests.

Examples of our primary **audiences** are policy makers, advisors, and researchers; and, state and community program developers, leaders, and activists. However, we have adopted an operating principle of "wherever two or more are gathered" we will come.

Core Messages:
"Making Health Care Work for Everyone" has been our **unifying theme** since the inception of the grant. It is used on most of our general information as a tag line. We chose it because it allows us to convey several key messages, for example: (1) Washington's health care system needs to work for everyone who has a stake in it – financers, deliverers, receivers, (2) the goal to get everyone covered is a means to an end, the end being a healthier and more financially secure population, and (3) there will always be some subset of the population (e.g., homeless, undocumented immigrants) that will not be covered and we still need to ensure their access to care.

Beyond that unifying theme, we try to tailor our messages depending on the audience, what we're trying to communicate, and the nature of the interaction we want to have. In general, however, we weave-in **core messages** about (1) who Washington's uninsured are (e.g., most are members of working families – they build our homes, feed us, take care of our young children and aging parents), and (2) the personal and societal consequences of being uninsured (e.g., the uninsured live sicker and die earlier; better health improves individual earnings and in turn our local and state economies; many of us are one job or one birthday away from losing coverage).

Examples of audience specific messages include:

a. **Coverage Options**: Pragmatic and resilient strategies to achieving broad coverage will cost money, will require melding of divergent values, and will need to build on currently accepted and trusted systems.
b. **Insurance Coverage**: Access to Coverage ≠ Access to Care. (Nonetheless: Although health insurance is not the only key to accessing care and improving health, it is among the most easily changed.)
c. **Individual Affordability**: Although not the only barrier to coverage, affordability is the most prominent and persistent for low-income families (e.g., for many families, affordability for private coverage starts at about 250% of federal poverty).
d. **Quality and Administrative Simplification**: Some of our best opportunities for redirecting system dollars to pay for covering the uninsured will, in the long run, come from addressing poor quality and inefficient administration (e.g., 25-30% of every direct health care dollar goes to poor quality and waste).
e. **System Sustainability**: Today's fiscal challenges underscore the need to develop a system (especially for public programs) that can weather future economic downturns better than we are doing so today.
f. **Federal / State Roles**: Some issues are national issues for which the federal government must step up and take responsibility so that state dollars can be redirected (e.g., Medicare prescription drug program).
g. **Local Innovation**: Not all solutions need be, nor should be, top-down. Much creative work regarding coverage and delivery is occurring in local communities that should be supported in their efforts. It is equally important, however, that local solutions be assessed in terms of broader community-to-community and population-to-population impacts.
h. **Data Ins and Outs**: The state population survey is a tremendous source of information, <u>when used correctly</u>.

Also, based on recent "profile" information we have begun incorporating the following message: While Washington's uninsured rate is on the rise, it is important not to lose sight of the good we have done and the strategies that have worked for us in the past.

Examples of communication materials:

Our major **communication materials** have been (1) research and policy reports, (2) fact sheets – briefing papers, and (3) general use of our project website as the primary distribution system for all written materials. This year we undertook a major revision of the project web site to ensure the research and information prepared under the grant is incorporated into other health research sponsored by the state and more effectively linked to existing information in a 'clearinghouse' fashion. The web redesign also incorporated our goal of ensuring the information will "live on" after the funded lifecycle of the grant itself.

Effective Channels:

Our most effective **"on-going" channels** have been (1) electronic (including our website http://www.ofm.wa.gov/accesshealth/accesshealth.htm and E-Mail Alert system), (2) personal interactions (including one-on-one and small group meetings, and participation in and support of others' work groups, advisory and steering committees, and task forces), and (3) actively encouraging use of our research work (either "as is" or repackaged to fit needs). We have purposefully shied away from *broad* media coverage, however we have provided information to the media when revised messages were important.

Greatest challenges or barriers in communicating:
Greatest **challenges** included: (1) the sad state of the economy and thus people's ability to "hear" a message about expanding coverage and (2) resistance to "policy lessons" from our/others' research/practical findings when those findings do not support the pragmatic decisions that need to be made or the popular idea of the moment. (Findings regarding coverage affordability for low-income families and findings regarding the ineffectiveness of small employer pools – as currently designed - to significantly reduce costs are examples.)

To work within these challenges we (1) adopted an approach that did not include "pushing" for buy-in on specific options (although our research work did involve developing options), (2) acknowledged that consensus building on strategies viable in Washington would occur over the long run through processes fed by the work of the grant but not unique to the grant (e.g., the Legislative process) and (3) elected to "key into" what people are willing to focus on as common-ground starting points (e.g., employees of small business, children, the state becoming a better partner (especially in areas of administrative simplification), coverage and access in rural areas, sustaining public program gains).

APPENDIX I: BASELINE INFORMATION

Baseline information on Washington State is available in the 2001 Washington State Data Book: http://www.ofm.wa.gov/databook/index.htm

The following data are from year 2000.

Population: **5,894,121**

Average age of population: **35.3 years**

Percent of population living in poverty (<100% FPL): **11.9%**

Primary Industries: **Agriculture, Forestry, Fishing, Mining, Manufacturing, Construction, Transportation, Wholesale/Retail, Financial/Insurance/Realty Services**

Number and percent of employers offering coverage: **63.4%**

Insurance market reforms: http://www.insurance.wa.gov/newsrel/6067facts.htm

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

Most of the information regarding our research work has been posted to our website at, http://www.ofm.wa.gov/accesshealth/accesshealth.htm as it becomes available.

APPENDIX III: REFERENCED ATTACHMENTS

Table of Contents

APPENDIX III: SECTION 1 UNINSURED INDIVIDUALS AND FAMILIES

APPENDIX III: SECTION 2 EMPLOYER-BASED COVERAGE

Washington State Planning Grant on Access to Health Insurance

Distribution of Workers in Washington, 2000 by Characteristics of Business

(Excerpted from draft consultant report on Profiles of Washington's Uninsured) *

Characteristic of business	All Business	Low wage Business (a)	Other Business (b)	Small Business (c)	Large Business (d)
Size of firm					
Fewer than 10 workers	22.0	30.4	19.9	51.2	0.0
10-50	21.0	24.7	20.1	48.8	0.0
50 or more	57.0	44.9	60.0	0.0	100.0
Low-wage business	20.0	100.0	0.0	25.6	15.7
Other business	80.0	0.0	100.0	74.4	84.3
Employs mostly part-time workers (e)	5.6	88.7	95.8	92.5	95.7
Employs less half part-time workers	94.4	11.3	4.2	7.5	4.3
Seasonal business (f)	5.4	9.4	4.4	4.7	5.9
Not seasonal	94.6	90.6	95.6	95.3	94.2
Has union workers	27.5	4.6	16.7	4.3	45.1
No union workers	72.5	95.4	33.2	95.7	54.9
Employs predominantly young workers (g)	22.2	41.5	17.5	27.4	18.5
Other business	77.7	58.5	82.5	72.6	81.5
Employs mostly female workers (h)	7.1	17.8	4.4	9.1	5.6
Other business	92.0	82.2	95.6	90.9	94.4

(a) at least 2/3 of workers in the business earn less than $10 per hour
(b) fewer than 2/3 of workers in the business earn less than $10 per hour
(c) business employs 50 or fewer workers
(d) business employs more than 50 workers
(e) at least half of workers in the business work fewer than 20 hours per week
(f) half of workers in the business are temporary or seasonal
(g) more than 30 percent of workers in the business are less than age 30, and no workers are older than 50
(h) at least 90 percent of workers in the business are female

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

APPENDIX III: SECTION 3 HEALTH CARE MARKETPLACE

Washington State Planning Grant on Access to Health Insurance

How the Self-Sufficiency Standard Is Calculated

(Excerpted from draft consultant report of Income Adequacy and the Affordability of Health Insurance in Washington State as found in *The Self-Sufficiency Standard for Washington State,* by Pearce, Diana. September, 2001.) *

The goal of making the Standard as standardized and accurate as possible, yet varied geographically and by age, requires meeting several different criteria. As much as possible, the figures used here:

1. are collected or calculated using standardized or equivalent methodology,
2. come from scholarly or credible sources, such as the U.S. Bureau of the Census,
3. are updated at least annually, and
4. are age- and/or geographically-specific (where appropriate).

Thus, costs that rarely have regional variation (such as food) are usually standardized, while costs such as housing and childcare, which vary substantially, are calculated at the most geographically- specific level available.

For each county or sub-county area in Washington, the Self-Sufficiency Standard is calculated for 70 different family types—all one-adult and two-adult families, ranging from a single adult with no children, to one adult with one infant, one adult with one preschooler, and so forth, up to two-adult families with three teenagers. The costs of each basic need and the Self-sufficiency Wages for all 70 family types for all geographic areas may be found in the Full Report. We have included the costs of each basic need and the Self-sufficiency Wages for eight selected family types for each county in Washington in the Appendix to this report.

The components of the Self-sufficiency Standard for Washington and the assumptions included in the calculations are described below.

Housing: The Standard uses the Fiscal Year 2001 Fair Market Rents for housing costs, which are calculated annually by the U.S. Department of Housing and Urban Development for every metropolitan housing market and non-metropolitan county (totaling over 400 housing market areas). Fair market rents are based on data from the decennial census, the annual American Housing Survey, and telephone surveys.[1] The Fair Market Rents (which include utilities except telephone and cable) are intended to reflect the cost of housing that meets minimum standards of decency, but is not luxurious. They reflect the cost of a given size unit at the 40th percentile level. (At the 40th percentile level, 40 of the housing in a given area would be less expensive than the FMR, while 60% would cost more than the FMR.

[1] These costs are based on a survey of units that have been on the market within the last two years, and exclude new housing (two years old or less), and substandard public housing.

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

The Standard has recently incorporated Payment Standards, which are adjustments to the FMR by local Public Housing Authorities (PHA). Each PHA has the authority to vary their payment standards by a range of 90-110%, based on the local market, and may do so in specific areas and even by size of unit. If there is a need to adjust the FMRs even further (above 110), the PHA may seek the required approval from the state's HUD office for an "exception" rent. Most exception rents are 120, or the 50th percentile, but they are defined as anything over 110%.

The Self-sufficiency Standard assumes that parents and children do not share the same bedroom and that there are not more than two children per bedroom. Therefore, the Standard assumes that single persons and couples without children have one-bedroom units;[2] families with one or two children require two bedrooms, and families with three children, three bedrooms.

Childcare: The Standard uses the most accurate information available that is recent, geographically-specific, and age- and setting- specific. In most states, this is the survey of childcare costs originally mandated by the Family Support Act, which provides the cost of childcare at the 75th percentile, by age of child and setting (family day care home, day care center, etc.).[3]

For Washington, the Standard uses the 3rd Quarter-Year 2000 Regional Market Rate (RMR) Ceilings, which are based on the results of a statewide survey of over 8,400 childcare providers conducted by the Washington State Childcare Resource and Referral Network. The rates given are the DSHS reimbursement rates and are specified by age, setting, and county.

Because it is more common for very young children to be in day care homes rather than centers,[4] the Standard assumes that children less than three years of age (infants and toddlers, called "infants" here) receive full-time care in day care homes. Preschoolers (three through five years old), in contrast, are assumed to go to day care centers full-time. School-age children (ages six to 12) are assumed to receive part-time care in before- and after-school programs.

Food: Although the Thrifty Food Plan is used as the basis of both the poverty thresholds and the Food Stamps allotments, the Standard uses the Low-Cost Food Plan for food costs.[5] While both of these USDA diets meet minimum nutritional standards, the Thrifty Food Plan was meant for emergency use only, while the Low-Cost Food Plan is based on more realistic assumptions about food preparation time and consumption patterns. Although the Low-Cost Food Plan amounts are

[2] Because of the lack of availability of efficiencies in some areas, and their very uneven quality, it was decided to use one-bedroom units for the single adult and childless couple.

[3] Under the 1988 Family Support Act (which was superceded by the Personal Responsibility and Work Opportunity Reconciliation Act, passed in 1996), states were required to fund or reimburse child care needed by those on welfare (or leaving welfare) at market rate, which was defined as the 75th percentile, for the age of child, setting, and location. Most states conducted surveys of costs, or commissioned child care referral networks or researchers to do these studies.

[4] Child care centers are more frequently used for older children (two to four years old) than for infants (J.R. Veum and P.M. Gleason. October, 1991. "Child Care Arrangements and Costs." *Monthly Labor Review.* p. 10-17.) However, particularly for younger children and lower-income parents, relative care (other than the parent) accounts for significant amounts of child care for children under three (27% compared to 17% in family day care and 22% in child care centers). It should be noted that relative day care is usually, but not always, in the relative's home, and is usually, though not always, paid; thus it more closely resembles (and may actually be) day care homes rather than day care centers. For children three years and older, the predominant child care arrangement is the child care center, accounting for 45% of the care (compared to 14% in family child care, and 17% in relative care.) See J. Capizzano, G. Adams, and F. Sonenstein. March 2000. *Child Care Arrangements for Children under Five: Variation across States.* Washington, DC: The Urban Institute. National Survey of America's Families, Series B, No. b-7.

[5] Because the USDA does not produce annual averages for food costs, the Standard follows the Food Stamps Program and uses the costs for June as an annual average.

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

about 25 higher than the Thrifty Food Plan, they are nevertheless conservative estimates of the level of food expenditures required to meet nutritional standards. The Low-Cost Food Plan does not allow for any take-out, fast food, or restaurant meals, even though, according to the Consumer Expenditure Survey, average American families spend about 42 of their food budget on food eaten away from home. Again, the choice to use this food budget reflects what it costs to adequately meet nutritional needs, not consumer behavior.

The food costs in the Standard are varied according to the number and age of children and the number and gender of adults. Since there is little regional variation in the cost of food overall, the Standard uses the national average throughout the State of Washington.

Transportation: If there is an adequate public transportation system in a given area, it is assumed that workers use public transportation to get to and from work. A public transportation system is considered "adequate" if it is used by a substantial percentage of the population to get to work. According to one study, if about 7 of the total public uses public transportation that "translates" to about 30 of the low- and moderate- income population.[6] The city of Seattle is the only area in Washington in which substantial numbers of workers use public transportation to get to and from work, with nearly 16% of those in the city of Seattle using public transportation.

Elsewhere in the state, the proportion using public transportation is much less, and therefore it is not a reasonable assumption that workers would be able to get to work by public transportation. Therefore, we assume only workers living in the city of Seattle use public transportation. For all others, it is assumed that adults require a car to get to and from work; if there are two adults in the family, we assume two cars. (It is unlikely that two adults with two jobs would be traveling to and from the same place of work, at exactly the same time.)

Data for public transportation costs are based on the cost of a monthly pass for each adult. Private transportation costs are based on the costs of owning and operating an average car (or two cars, if there are two adults). The costs include the fixed costs of owning a car (including fire and theft insurance, property damage and liability, license, registration, taxes, repairs, and finance charges), in addition to monthly variable costs (e.g., gas, oil, tires, and maintenance), but do not include the initial cost of purchasing a car.

To estimate fixed costs, we use the Consumer Expenditure Survey amounts for families in the second quintile (those whose incomes are between the 20th and 40th percentile) of income, by region. In Washington, there are differences in costs by region, with auto insurance costing more in King and Pierce counties. Therefore, we varied the insurance portion of the fixed costs by a ratio computed from a study of insurance costs differentials done by the Office of the Insurance Commissioner for Washington and the gas cost based on AAA Surveys.[7] For varied costs, the Standard assumes that the car(s) will be used to commute to and from work five days per week, plus one trip per week per family for shopping for food and other errands. (The commuting distance is computed using the statewide average from the National Personal Transportation Survey). In addition, one parent in each household with young children is assumed to have a slightly longer weekday trip to allow for "linking" trips to the day care center or home.

---

[6] See C. Porter and E. Deakin. December 1995. *Socioeconomic and Journey-to-Work Data: A Compendium for the 35 Largest U.S. Metropolitan Areas.* Berkely, CA: Institute of Urban and Regional Development, University of California at Berkely.

[7] *Premium Comparison of Largest Auto Insurance Writers in Washington.* Washington Insurance Commissioner's Office: www.insurance.state.pa.us/html/cauto.html

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Health Care: Health care costs in the Standard include both the employee's share of insurance premiums plus additional out-of-pocket expenses, such as co-payments, uncovered expenses (e.g., dental care and prescriptions), and insurance deductibles.

Although workers who do not have employer-provided health insurance often "do without," families cannot be truly self-sufficient without health insurance. The Self-Sufficiency Standard assumes that the employer provides health insurance coverage,[8] and that employees pay a portion of the premium for coverage (usually about one-fourth of the cost for employee only, and about one-third for family coverage).[9] The costs of health insurance in Washington are based on data from the Office of the Insurance Commissioner for Washington which was produced by the National Institute for Health Care Management. To capture the geographical differences in costs, we varied the health insurance premiums by a ratio computed from available HMOs through the Health Care Authority of Washington.

Data for out-of-pocket health care costs (by age) were obtained from the National Medical Expenditure Survey, adjusted by state using the Families USA report, *Skyrocketing Health Inflation: 1980-1993-2000*, and adjusted for inflation using the Medical Consumer Price Index (Medical CPI).

Miscellaneous: This expense category includes all other essentials such as clothing, shoes, paper products, diapers, nonprescription medicines, cleaning products and household items, personal hygiene items, and telephone. It does not allow for recreation, entertainment, or savings. Miscellaneous expenses are calculated by taking 10 of all other costs. This percentage is a conservative estimate in comparison to estimates in other basic needs budgets, which usually use 15%.[10]

Taxes: Taxes include state sales tax, federal and state income taxes, and payroll taxes. The retail sales tax varies by locality from 7.5 to 8.6, with no tax on food. Sales taxes are calculated only on "miscellaneous" items, as one does not ordinarily pay tax on rent, childcare, and so forth. (As is the case in many states, Washington does not tax services.) Indirect taxes, e.g., property taxes paid by the landlord on housing, are assumed to be included in the price of housing passed on by the landlord to the tenant. Also, taxes on gasoline and automobiles are included as a cost of owning and running a car.

State income taxes are calculated using the Commerce Clearinghouse State Tax Handbook as well as tax forms from the Washington Department of Revenue. The federal income tax calculation assumes the standard deduction and exemptions, and includes tax credits, both refundable and nonrefundable. There is no state income tax in Washington.

Payroll taxes for Social Security and Medicare are calculated at 7.65% of each dollar earned. Although the federal income tax rate is higher than the payroll tax rate—15% of income for families in this range—federal exemptions and deductions are substantial. As a result, families

[8] According to the Bureau of Labor Statistics, 83% of non-temporary workers have health insurance provided through their employer.

[9] A. Foster Higgins & Co., Inc., *Tables: National Survey of Employer-Sponsored Health Plans, 1993-1996* (Princeton, NJ: A. Foster Higgins & Co., Inc., 1994-1997), and William M. Mercer, Inc., *Tables: National Survey of Employer-Sponsored Health Plans, 1997 and 1998,* (New York, NY: William M. Mercer, Inc., 1998 and 1999).

[1010] See C. Citro and R. Michael, eds., *Measuring Poverty: A New Approach*, Washington, DC: National Academy Press, 1995.

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

do not pay federal income tax on the first $10,000 to $ 12,000 or more, thus lowering the effective federal tax rate to 7% to 10% for many taxpayers.

Earned Income Tax Credit (EITC): The EITC, or as it is sometimes called, the Earned Income Credit, is a federal tax refund intended to offset the loss of income from payroll taxes owed by working-poor and near-poor families. The EITC is "refundable"; that is, working adults may receive the tax credit whether or not they owe any federal taxes, adding to their income.

Childcare Tax Credit (CCTC): The CCTC is a federal tax credit that allows working parents to deduct a percentage of their childcare costs from the federal income taxes they owe. Like the EITC, the CCTC is deducted from the total amount of money a family needs to be self-sufficient. Unlike the EITC, the federal CCTC is not a "refundable" tax credit. A family may only receive the CCTC as a credit against federal income taxes owed. Therefore, families who pay little or no federal income taxes, receive little or no CCTC.

Child Tax Credit (CTC): The CTC is a federal tax credit that allows parents to deduct up to $500 per child (for children less than 17 years old) from the federal income taxes they owe. If a family has one or two children, it is calculated like the CCTC, as a credit against federal taxes owed. If the family does not owe federal taxes, or has already taken the CCTC and there is no remaining liability (that is, no federal tax is owed after the CCTC is taken), then the family is not eligible for the CTC. However, if there are three or more children, then the CTC becomes refundable (as with the EITC). In this case, the family may receive the credit (up to $500 per child), even if they do not owe any federal taxes. However, the amount of CTC they receive is limited to the amount their payroll tax exceeds the EITC that they have or will receive. Starting in 2002, the CTC will be refundable for those with earnings over $10,000.

Given the high costs of childcare, most families with young children who pay market rate childcare offset most or all of the federal taxes they owe with their childcare tax credit. However, those with older children, or three or more children and higher incomes, are more likely to receive the CTC.

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Washington State Planning Grant on Access to Health Insurance

Methods For Developing Adjusted Standard

(Excerpted from draft consultant report on Income Adequacy and the Affordability of Health Insurance in Washington State) *

The purpose of the affordability analysis is to answer the primary question:

> **At what income level can family type *a*, living in county *b*, with health status *x* afford to buy coverage option *t* after paying for other basic living expenses?**

The analysis requires decisions about family type, geographic region, health status, and coverage options.

Family Type

From the 70 family types used to calculate the Self-Sufficiency Standard, we chose 12 family types for this analysis (Table 3). The basis for our selection was evidence about those family types most likely to be uninsured and those family types that represent large numbers of Washington families. For example, we included the single-adult family with no children to reflect the fact that young adults (ages 19-34) made up the largest proportion of the uninsured in Washington in 2000 (43.4 percent) and had the highest rate of uninsurance (16.5 percent) of any age category. The two-adult family with no children represents an age group (55-64) that accounted for another 6.5 percent of the uninsured population in 2000, with an uninsurance rate of 5.9 percent.

Table 3. Description of Family Types

Abbreviation	Family Type
1A	1 Adult (age 20), no children
1A, 1I	1 Adult (age 20), 1 infant
1A, 1S	1 Adult (age 30), school age child
1A, 1T	1 Adult (age 40), 1 teenager
1A, 1I, 1P	1 Adult (age 20), 1 infant, 1 preschooler
1A, 2S	1 Adult (age 30), 2 school age children
1A, 2P, 2S, 1T	1 Adult (age 40), 2 preschoolers, 2 school age children, 1 teenager
2A	2 Adults (age 55), no children
2A, 1I, 1P	2 Adults (age 30), 1 infant, 1 preschooler
2A, 2S	2 Adults (age 30), 2 school age children
2A, 2T	2 Adults (age 40), 2 teenagers
2A, 1P, 1S, 1T	2 Adults (age 40), 1 preschooler, 1 school age child, 1 teenager

Although the Standard does not distinguish among adults of different ages, health insurance premiums frequently do vary by age of adult. Therefore, we made assumptions about the ages of

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

adults in each family type to reflect the likely mean age of low-income uninsured adults. These assumptions are included in Table 3.

Geographic Area.

We used the geographic areas defined by the Washington State Population Survey (WSPS). We selected these areas to be consistent with other pieces of our analysis in which we used income and other data from the survey. The SPS areas include three single-county areas (King, Clark, and Spokane counties) and five multiple-county areas (North Sound, West Balance, Other Puget Sound Metro, East Balance, and Yakima-Tri-Cities). In multiple county areas, we selected a single county from among the most populous counties, based on feedback from a variety of stakeholders. The counties we selected (Whatcom, Jefferson, King, Pierce, Clark, Chelan, Spokane, and Yakima), their median incomes, and the Standard for a single-adult family with an infant and a preschool child are listed in Table 4.

Table 4. Counties and Income Adequacy

Geographic Area	*Median Income*	Self-Sufficiency (1A, 1I, 1P)
1. North Sound: Whatcom	$42,272	$39,136
2. West Balance: Jefferson	$39,045	$35,815
3. King County	$62,735	$41,843
4. Other Puget Sound Metro: Pierce	$49,265	$38,318
5. Clark County	$53,418	$39,473
6. East Balance: Chelan	$35,500	$30,906
7. Spokane County	$41,795	$33,658
8. Yakima Tri-Cities: Yakima	$35,183	$32,357

Note: A=Adult, I=Infant, P= Preschool child
Source: 2000 State Population Survey Geographic Regions; Median Income by County (2001 Forecast). www.ofm.wa.gov/poptrends/table16.pdf; Self-Sufficiency Standard for WA State, September 2001, by Diana Pearce, PhD.

Health Care Costs

Because we are interested in a measure of the affordability of specific health insurance options that may be available to low-income families, we substituted several of our own estimates of health care costs for the Standard's estimates. The Standard's health care cost estimates were based on data from the National Medical Expenditure Survey. Our estimates, like the Standard's figures, included both the share of premiums paid by families and their estimated out-of-pocket costs (e.g., deductible, copayments, uncovered services). We added our estimates of health care expenditures to the other living expenses in the Standard to calculate the Adjusted Self-Sufficiency Standard (the Adjusted Standard).

Coverage Options and Insurance Premiums

Premiums for health insurance vary by type of coverage. We wanted to include the major coverage options likely to be available to lower-income families in Washington. These include: Healthy Options, Basic Health (BH—subsidized and unsubsidized), BH+ (for children), State Children's Health Insurance Program (SCHIP), Washington State Health Insurance Pool (WSHIP), individual insurance, small-group insurance, and large-group insurance. For purposes

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

of this analysis, we omitted the unsubsidized BH option on the grounds that this program is closed to new enrollees and will be for the foreseeable future. We omitted SCHIP on the grounds that it is a very small program, and most children will be covered through either Healthy Options or BH+. We also omitted the large-group insurance option on the grounds that it is more affordable because it typically has lower premium costs for a given set of benefits. We combined BH and BH+, assuming that families who are eligible for (and choose) BH can and would enroll their children in BH+. Finally, we assumed that only one adult from a family would be screened into WSHIP, while other family members would be covered by an individual product.

For individual coverage, we assumed that the family purchases a policy for each family member. For small-group coverage, we assumed that only one worker is covered per family, with additional family members (including other adults) covered as dependents. We assumed that employers pay 75 percent of the premium for single adults and 50 percent for dependents. This reflects the fact that small-group coverage typically subsidizes dependents less than employees.

In recognition of the fact that the very lowest-income level families may have access to non-health care subsidies (e.g., child care subsidies and food stamps), the two options that target these families are modeled in two ways: one assuming other subsidies and one assuming no other subsidies. Thus, the seven coverage options we modeled are:

1. Medicaid, no other subsidies
2. Medicaid, other subsidies (food stamps and child care, as used in the Pearce model)
3. BH/BH+, no other subsidies
4. BH/BH+, other subsidies (as above)
5. Small-group coverage
6. Individual coverage
7. WSHIP/Individual

We used premium data for the public programs from published program materials and telephone conversations with agency staff. For BH we calculated premiums based on the upper income level (175-199 percent FPL) with children eligible for no-cost BH+ coverage. For WSHIP we selected Plan 3—Network Plan (Non-Medicare) $500 deductible program. This option has the highest current enrollment (other than the Medicare option). WSHIP discounts for members over age 50 with income < 301% FPL and for members with continuous coverage were not included in our analysis.

For the individual coverage option we selected the Premera Personal Prudent Buyer Program Option 2—$500 deductible plan for non-smokers. This program is available in all but one county and represents a common plan design. We derived the premium figures from a carrier survey conducted by the study team for this project by William M. Mercer, Inc.

For small-group coverage we obtained information from several sources, including brokers and health plans. We developed an average plan and premium based on all sources of information. That plan design included a $200 deductible, 90 percent coinsurance, $15 copay per prescription, and a $2,500 out-of-pocket maximum. The baseline premium for 2001 is estimated at $210 per employee per month, $262.50 (25 percent more) for spouses, and $189 (90 percent of employee

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

rate) for any number of children in a family. These factors and this rate tier structure are commonplace.

In general, health insurance premiums do not vary by geographic regions as small as counties. Healthy Options is free to all enrollees across the state. BH premiums are statewide (the lowest-cost plan was offered in all regions in 2001), and WSHIP premiums no longer vary by region. In the individual market there is some variation within some carriers. However, the program we selected has statewide premium rates. For the small-group market we believe the geographic variation in rates is small and overshadowed by other rating factors. One point estimate we were able to obtain showed less than a 5 percent variation across the regions of this study.

Health Status and Out-of-Pocket Expenses

Families incur out-of-pocket health care expenses in addition to premiums, including deductibles, copayments, and expenses for services that are not covered by insurance. In recognition of the fact that families whose members have different health status have different out-of-pocket expenses, we selected three levels of health status and made assumptions about their use of services.

Healthy: No out-of-pocket costs beyond the insurance premium

Average: Out-of-pocket costs were calculated as the sum of members' copayments, coinsurance, and deductibles divided by the total cost of health care including administration. For example, if every member had only one office visit with a $10 copay, the average out-of-pocket costs would be 1 percent of an annual premium of $1000.

Sick: Cost sharing for a sicker family member is somewhat more complex. In plans with out-of-pocket maximum caps for members, we used that amount as an upper level of out-of-pocket costs. For plans without such features, out-of-pocket costs could be (theoretically) infinite. Where caps on out-of-pocket expenses did not exist, we targeted the out-of-pocket costs for a member at the 90th percentile of total costs.

Because this is a family analysis, and in recognition of time and budget constraints, we assumed that all family members had the same health status for the healthy and average families. For the sick families, we assumed that two family members hit the out-of-pocket limit or 90th percentile. Although we recognize that this may not perfectly reflect many families' health status, it represents a reasonable compromise between the need for analytic simplicity and the complexity of reality.

When we assessed the out-of-pocket costs for the "sick" family in the WSHIP/Individual insurance option, we assumed that the WSHIP member and one other family member hit their out-of-pocket maximum limit. All out-of-pocket costs were calculated using standard actuarial procedures and tables representing health care utilization and cost per service for a commercially insured population.

Total Health Care Expenses

Health care premiums across coverage options and family composition vary from zero to $9064 for single-adult families (the latter figure is for a single adult in WSHIP and five children with individual insurance), and from zero to $9580 for two-adult families (the latter figure is for two adults, one of whom is in WSHIP and one of whom has individual insurance, and three children

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

all of whom have individual insurance). Premiums for Medicaid coverage are zero for all family types and health status levels; out-of-pocket costs are zero for healthy families of all types and for all coverage options. Premiums for BH/BH+ are lower than the private options for all families. Premiums for individual coverage are lower than for small-group coverage for all single-adult families except the largest one; for two-adult families, relative premiums of the two options vary by family type. The WSHIP/Individual option's premium also varies in relation to the other private options, but it is frequently highest. Tables 5A through 5D give the estimates for premiums and out-of-pocket costs for all family types, all health status levels, and all five insurance programs.

Table 5A. Annual Health Care Costs for Private Coverage Options in One-Adult Publicly Insured Families, all Washington Counties

Family Type	Healthy Options			Basic Health		
	Premium	Out of Pocket	Total	Premium	Out of Pocket	Total
1 Adult						
Healthy	0	0	0	1555	0	1555
Average	0	0	0	1555	210	1765
Sick	0	0	0	1555	1300	2855
1 Adult, 1 infant						
Healthy	0	0	0	1555	0	1555
Average	0	0	0	1555	210	1765
Sick	0	0	0	1555	1300	2855
1 Adult, 1 school age child						
Healthy	0	0	0	1555	0	1555
Average	0	0	0	1555	210	1765
Sick	0	0	0	1555	1300	2855
1 Adult, 1 teenager						
Healthy	0	0	0	1994	0	1994
Average	0	0	0	1994	269	2263
Sick	0	0	0	1994	1300	3294
1 Adult, 1 infant, 1 preschool						
Healthy	0	0	0	1555	0	1555
Average	0	0	0	1555	210	1765
Sick	0	0	0	1555	1300	2855
1 Adult, 2 school age						
Healthy	0	0	0	1555	0	1555
Average	0	0	0	1555	210	1765
Sick	0	0	0	1555	1300	2855
1 Adult, 2 preschool, 2 school age, 1 teenager						
Healthy	0	0	0	1994	0	1994
Average	0	0	0	1994	269	2263
Sick	0	0	0	1994	1300	3294

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Table 5B. Annual Health Care Costs for Private Coverage Options in One-Adult Privately Insured Families, all Washington Counties

Family Type	Small Group			Individual			WSHIP/Individual		
	Premium	Out of Pocket	Total	Premium	Out of Pocket	Total	Premium	Out of Pocket	Total
1 Adult									
Healthy	2520	0	2520	1728	0	1728	2170	0	2170
Average	2520	408	2928	1728	526	2254	2170	374	2544
Sick	2520	3040	5560	1728	2680	4408	2170	1500	3670
1 Adult, 1 infant									
Healthy	4788	0	4788	2856	0	2856	3298	0	3298
Average	4788	776	5564	2856	869	3725	3298	718	4016
Sick	4788	6080	10868	2856	5360	8216	3298	4180	7478
1 Adult, 1 school age child									
Healthy	4788	0	4788	3216	0	3216	3861	0	3861
Average	4788	776	5564	3216	979	4195	3861	815	4676
Sick	4788	6080	10868	3216	5360	8576	3861	4180	8041
1 Adult, 1 teenager									
Healthy	4788	0	4788	3900	0	3900	4552	0	4552
Average	4788	776	5564	3900	1187	5087	4552	934	5486
Sick	4788	6080	10868	3900	5360	9260	4552	4180	8732
1 Adult, 1 infant, 1 preschool									
Healthy	4788	0	4788	3984	0	3984	4426	0	4426
Average	4788	776	5564	3984	1213	5197	4426	1061	5487
Sick	4788	6080	10868	3984	5360	9344	4426	4180	8606
1 Adult, 2 school age									
Healthy	4788	0	4788	4344	0	4344	4989	0	4989
Average	4788	776	5564	4344	1322	5666	4989	1159	6148
Sick	4788	6080	10868	4344	5360	9704	4989	4180	9169
1 Adult, 2 preschool, 2 school age, 1 teenager									
Healthy	4788	0	4788	8412	0	8412	9064	0	9064
Average	4788	776	5564	8412	2561	10973	9064	2308	11372
Sick	4788	6080	10868	8412	5360	13772	9064	4180	13244

Table 5C. Annual Health Care Costs for Private Coverage Options in Two-Adult Publicly Insured Families, all Washington Counties

Family Type	Healthy Options			Basic Health		
	Premium	Out of Pocket	Total	Premium	Out of Pocket	Total
2 Adults						
Healthy	0	0	0	6818	0	6818
Average	0	0	0	6818	920	7738

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Table 5C. Annual Health Care Costs for Private Coverage Options in Two-Adult Publicly Insured Families, all Washington Counties

Family Type	Healthy Options			Basic Health		
Sick	0	0	0	6818	2600	9418
2 Adults, 1 infant,						
1 preschool						
Healthy	0	0	0	3110	0	3110
Average	0	0	0	3110	420	3530
Sick	0	0	0	3110	2600	5710
2 Adults, 2 school age						
Healthy	0	0	0	3110	0	3110
Average	0	0	0	3110	420	3530
Sick	0	0	0	3110	2600	5710
2 Adults, 2 teenagers						
Healthy	0	0	0	3987	0	3987
Average	0	0	0	3987	538	4525
Sick	0	0	0	3987	2600	6587
2 Adults, 1 preschool, 1 school age, 1 teenager						
Healthy	0	0	0	3987	0	3987
Average	0	0	0	3987	538	4525
Sick	0	0	0	3987	2600	6587

Table 5D. Annual Health Care Costs for Private Coverage Options in Two-Adult Privately Insured Families, all Washington Counties

Family Type	Small Group			Individual			WSHIP/Individual		
	Premium	Out of Pocket	Total	Premium	Out of Pocket	Total	Premium	Out of Pocket	Total
2 Adults									
Healthy	5670	0	5670	8424	0	8424	9572	0	9572
Average	5670	919	6589	8424	2564	10988	9572	2206	11778
Sick	5670	6080	11750	8424	5360	13784	9572	4180	13752
2 Adults, 1 infant, 1 preschool									
Healthy	7938	0	7938	6432	0	6432	7077	0	7077
Average	7938	1286	9224	6432	1958	8390	7077	1794	8871
Sick	7938	6080	14018	6432	5360	11792	7077	4180	11257
2 Adults, 2 school age									
Healthy	7938	0	7938	6432	0	6432	7077	0	7077
Average	7938	1286	9224	6432	1958	8390	7077	1794	8871
Sick	7938	6080	14018	6432	5360	11792	7077	4180	11257
2 Adults, 2 teenagers									
Healthy	7938	0	7938	7800	0	7800	8452	0	8452
Average	7938	1286	9224	7800	2374	10174	8452	2121	10573
Sick	7938	6080	14018	7800	5360	13160	8452	4180	12632

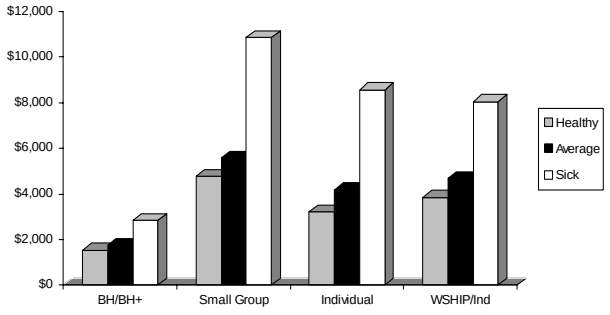
***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Table 5D. Annual Health Care Costs for Private Coverage Options in Two-Adult Privately Insured Families, all Washington Counties

Family Type	Small Group			Individual			WSHIP/Individual		
	Premium	Out of Pocket	Total	Premium	Out of Pocket	Total	Premium	Out of Pocket	Total
2 Adults, 1 preschool, 1 school age, 1 teenager									
Healthy	7938	0	7938	8928	0	8928	9580	0	9580
Average	7938	1286	9224	8928	2718	11646	9580	2465	12045
Sick	7938	6080	14018	8928	5360	14288	9580	4180	13760

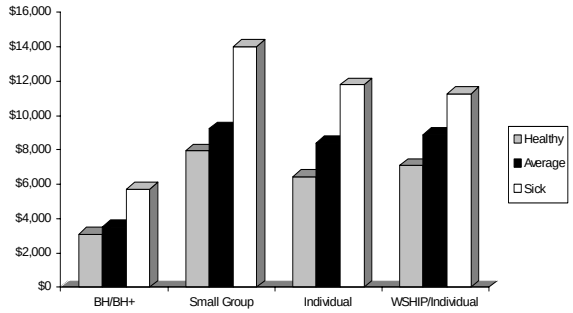
Total out-of-pocket health care expenses vary dramatically by family size, health status, and coverage option. Figures 8A and 8B illustrate this point for two family types. For the one adult/one school age child family type, sick families pay 267 percent of what healthy families pay for health care expenses with individual insurance. For the two adult/one infant/one preschool child family type, sick families pay 183 percent of what health families pay with individual coverage. For the single adult family type in Figure 8A, health care expenses for sick families with small-group coverage pay 381 percent of what sick families enrolled in BH/BH+ pay. For the two-adult family type in Figure 8B, that figure is 245 percent.

Figure 8A. Annual Health Care Expenses by Health Status: 1 Adult, 1 School-Aged Child, All Washington Counties



Note: Families enrolled in Medicaid have no out of pocket health care expenses.
Source: William M. Mercer, Inc.

Figure 8B. Annual Health Care Expenses by Health Status: 2 Adults, 1 Infant, 1 Preschool-Aged Child, All Washington Counties



Note: Families enrolled in Medicaid have no out of pocket health care expenses.
Source: William M. Mercer, Inc.

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Washington State Planning Grant on Access to Health Insurance

Measures of Income Adequacy

(Excerpted from draft consultant report on Income Adequacy and the Affordability of Health Insurance in Washington State) *

Federal Poverty Level

The need for an objective standard to assess income adequacy has led many policy makers to the official federal poverty measure. Using the federal poverty level, a family can be judged to be "poor" if its income is below the appropriate threshold and "not poor" if it is above the threshold. As Pearce (2001) points out, however, this measure has some significant limitations.

The federal poverty level was first developed in the early 1960s. It was based on the cost of a single item, food, and assumed a fixed ratio between food and all other components of families' living expenses (housing, clothing, etc.). This ratio, in turn, was based on spending patterns in the context of the dominant family composition of the time (two parent families with non-working wives), relative prices, and available products, housing stocks, and technology. The dollar amount of the FPL increases with family size.

Since the 1960s, the measure has been updated only for inflation, despite the fact that the composition of families has changed significantly, as has the context in which families make purchasing decisions. The needs of families with two working parents in particular—of whom there are many more today than in the 1960s—have changed to include child care for young children and transportation for the second worker. The FPL does not distinguish between families with one earner and two earners (or single-parent workers) despite the fact that these families have very different expenses associated with earning the same income.

An additional limitation of the FPL is that it does not vary by geographic location: it is the same for families in Republic or Seattle (as well as Mississippi and Manhattan). Although there was some geographic variation in costs even three decades ago, differences in the cost of living between areas have increased substantially since then, particularly in for housing. Housing in the most expensive areas of the country costs about four times as much as the same size units in the least expensive areas (Pearce, 2001). Finally, the FPL is increasingly viewed as simply too low, as evidenced by the fact that some public programs —including Medicaid in many states—set eligibility standards that are well over 100 percent of FPL.

Fifty Percent of Median Income

An alternative measure of income adequacy is 50 percent (or some other percentage) of median income. The advantage of this measure over the FPL is that is does vary by geographic region. In this report, we have measured the relevant geographic region by county. A significant limitation, however, is that median income is averaged over all family types. Thus, 50 percent of median county income is the same for a single-adult family as for a two-adult family with three children. Further, it does not take into account either levels or variations in living expenses by family type and geographic area.

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Full-Time Minimum Wage

Policy makers have set an income standard through the minimum hourly wage. Thus, another available income adequacy measure is this wage calculated at full employment for all adults in each family. The advantage of this measure is that it is based on legislative deliberation and varies with the number of workers in the family. However, the standard is statewide and, like median income, does not measure income in relation to living expenses or number of dependents.

The Self-Sufficiency Standard

A number of states have developed more sensitive measures of income adequacy by estimating basic living expenses for various family types and geographic areas. Researchers at the Josiah Bartlett Center for Public Policy in New Hampshire used mostly state-level data collected by various organizations to generate an estimate of a "livable wage" for seven family types for each New Hampshire county (Kenyon, 2000).[11] [12] Glazner (2001) used the same approach with 22 family types, but had to rely on national data from the Bureau of Labor Statistics Consumer Expenditure Survey (CES) for most expense categories. For health care expenditures, she combined health insurance premium data from Colorado's Alliance, a nonprofit membership organization that purchases health insurance for large and small employers, with CES data on non-covered health care expenses.

The Self-Sufficiency Standard, developed by Diana Pearce, is a similar measure of income adequacy (Pearce, 2001). The Self-Sufficiency Standard (the Standard):

> …measures how much income is needed, for a family of a given composition in a given place, to adequately meet its basic needs—*without public or private assistance.* By providing a measure that is customized to each family's circumstances, i.e., taking account of where they live, and how old their children are, the Self-Sufficiency Standard makes it possible to determine if a family's income is enough to meet its basic needs.
>
> The Standard does not try to combine, or average together, the very different circumstances of families in which adults work, compared to those in which they do not. Rather, the Self-Sufficiency Standard assumes that all adults (whether married or single) work full-time, and therefore, includes costs associated with employment, specifically transportation, taxes, and for families with young children, child care.
>
> The Standard takes into account that many costs differ not only by family size and composition, but also by the age of children. While food and health care costs are slightly lower for younger children, child care costs are much higher—particularly for children not yet in school—and are a substantial budget item not included in the official poverty measure.
>
> The Standard includes the net effect of taxes and tax credits. It provides for state sales taxes, as well as payroll (Social Security and Medicare) taxes, and federal and state income taxes. Three federal credits available to workers and their families are "credited"

[11] Data for out-of-pocket health care expenditures were estimated from national survey data.
[12] Researchers in Maine used a very similar approach. See Pohlmann, St. John, and Kavanaugh (2000).

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

against the income needed to meet basic needs: the Child Care Tax Credit, the Earned Income Tax Credit, and the Child Tax Credit.

While the poverty standard is based on the cost of a single item, food, and assumes a fixed ratio between food and nonfood, the Standard is based on the costs of each basic need, determined independently, which allows each cost to increase at its own rate. Thus, the Standard does not assume that food is always 33 percent of a family's budget, or constrain housing to 30 percent.

The Self-Sufficiency Standard is set at a level that is, on the one hand, not luxurious or even comfortable, and on the other, not so low that it fails to adequately provide for a family. Rather, the Standard provides income sufficient to meet minimum nutrition standards, for example, and to obtain housing that would be neither substandard nor overcrowded. The Standard does not, however, allow for longer-term needs, such as retirement, purchase of major items such as a car, or emergency expenses (except possibly under the "miscellaneous" cost category) (Pearce, 2001. pgs 1-4).[13]

The Standard is calculated for 70 different family types at the county (or in counties with distinct regions, the sub-county) level. It includes estimates of expenses in eight categories (see Table 1), including health care, taken from published sources.[14] Pearce and colleagues have calculated the Standard for a number of states, including Washington. Thus, the Standard, which has already been calculated for Washington State, provides a measure of income adequacy that is sensitive to family type and geographic variation.

Table 1. Expense Categories for Calculating the Self Sufficiency Standard

Housing	Health Care
Child Care	Miscellaneous
Food	Taxes
Transportation	Tax Credits

Comparisons

The four measures—federal poverty level, 50 percent of median income, full-time minimum wage, and the Self Sufficiency Standard—have different characteristics and draw upon different data. The Standard is greater than the FPL for all family types with children and all counties. Although FPL increases with family size, the Standard increases more rapidly. The Standard is also higher than 50 percent of median wage for the families with children for all counties; less for single-adult families. The latter result is expected because median income is averaged over families of all sizes. FPL is less than 50 percent of median income in all cases except for large two-parent families in Chelan County, where they are equal. Table 2 summarizes the differences with regard to variation by geographic region and family size.

[13] The New Hampshire livable wage includes 5 percent for savings; the Colorado income measure includes educational expenses, non-health insurance and pension contributions, and other cash contributions such as alimony payments and charitable donations.

[14] A complete description of how the Standard is calculated appears in Appendix A.

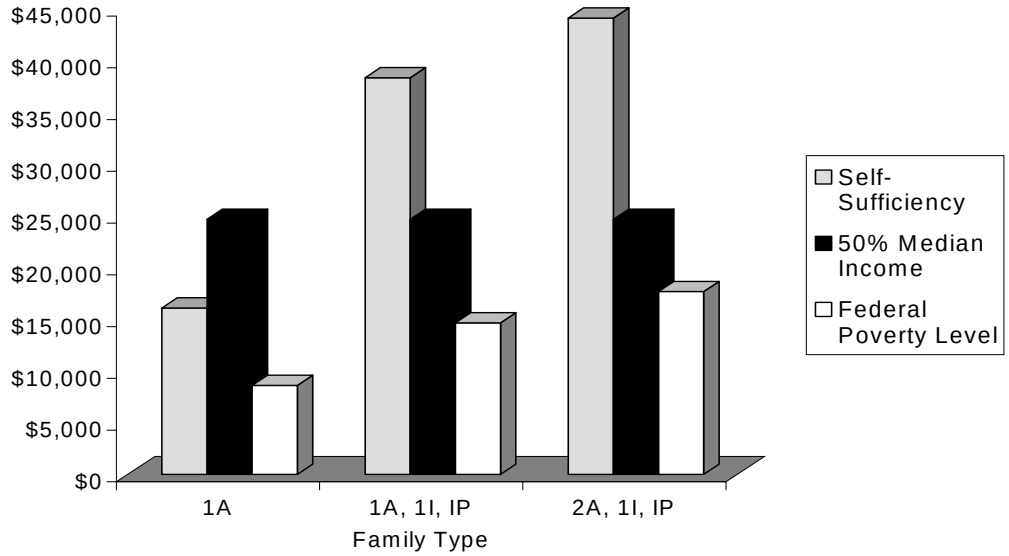
***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Table 2. Comparisons of Alternative Measures of Income Adequacy

Measure	Sources of Variation
Federal Poverty Level	- Varies by number of family members - Constant across counties
50% of County Median Income	- Varies by county - Constant across family types
Full-Time Earnings of Adults at Minimum Wage	- Varies by number of working adults - Constant across counties
Self-Sufficiency Standard for Washington State	- Varies by family type and county

Figures 1 through 4 illustrate these differences for FPL, 50 percent of median income, and the Self-Sufficiency Standard for three family types and four counties (Jefferson, Pierce [Tacoma], Chelan, and Spokane).

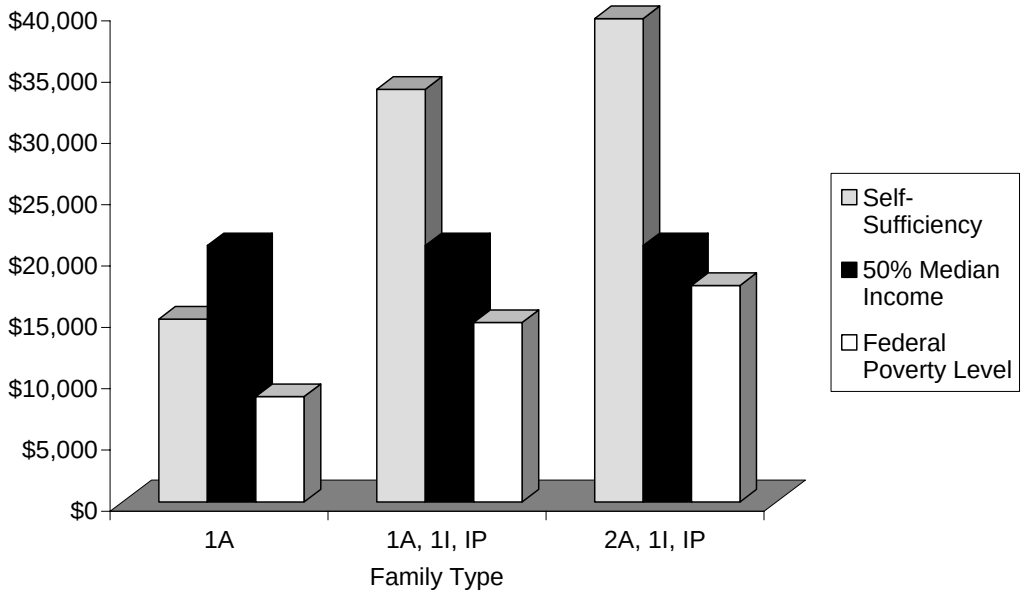
Figure 1. Comparison of Income Adequacy Measures: Pierce County



Note: A=Adult; I=Infant; P=Preschool age child
Source: 2001 Federal Poverty Guidelines (FPL). http://aspe.hhs.gov/poverty/01poverty.htm; Median Income by County (2001 Forecast) – http://www.ofm.wa.gov/poptrends/table16.pdf; Self-Sufficiency Standard for WA State, September 2001, by Diana Pearce, PhD.

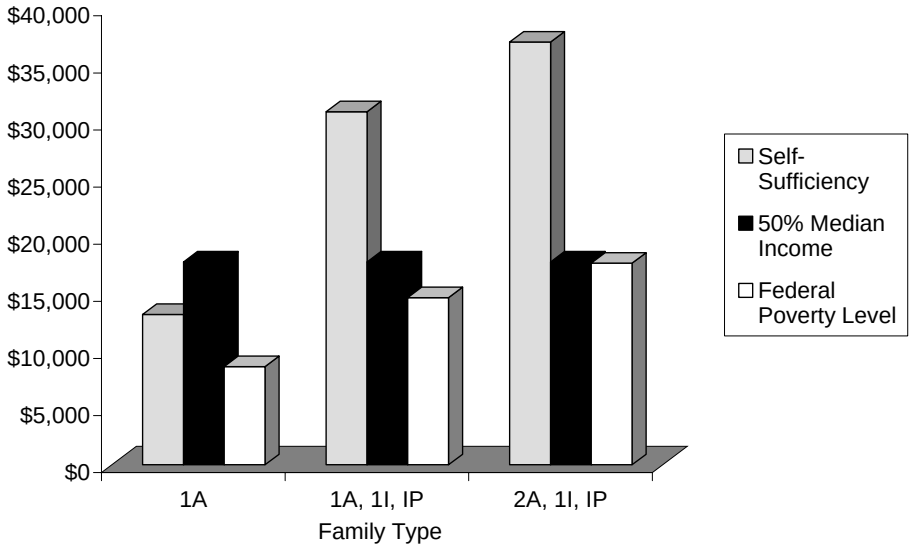
***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Figure 2. Comparison of Income Adequacy Measures: Jefferson County



Note: A=Adult; I=Infant; P=Preschool age child
Source: 2001 Federal Poverty Guidelines (FPL). http://aspe.hhs.gov/poverty/01poverty.htm; Median Income by County (2001 Forecast) – http://www.ofm.wa.gov/poptrends/table16.pdf; Self-Sufficiency Standard for WA State, September 2001, by Diana Pearce, PhD.

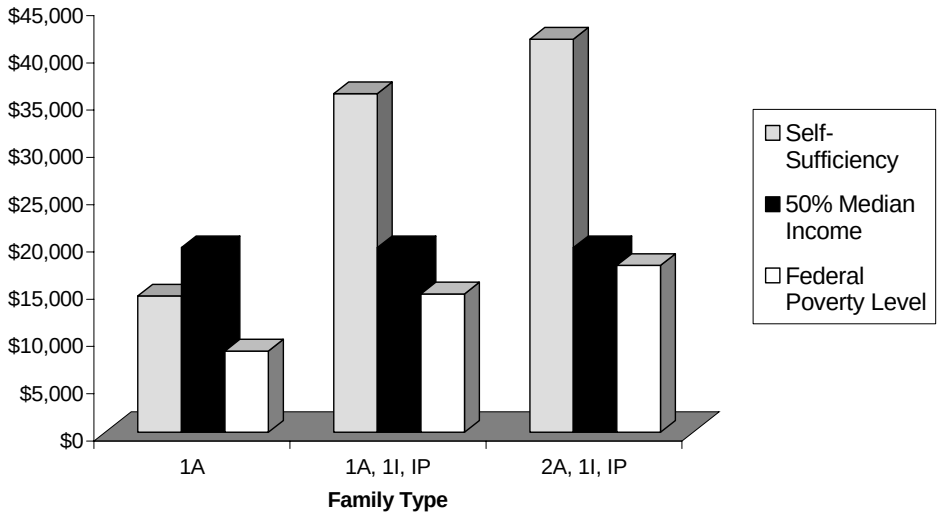
Figure 3. Comparison of Income Adequacy Measures: Chelan County



Note: A=Adult; I=Infant; P=Preschool age child
Source: 2001 Federal Poverty Guidelines (FPL). http://aspe.hhs.gov/poverty/01poverty.htm; Median Income by County (2001 Forecast). http://www.ofm.wa.gov/poptrends/table16.pdf; Self-Sufficiency Standard for WA State, September 2001, by Diana Pearce, PhD.

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Figure 4. Comparison of Income Adequacy Measures: Spokane County



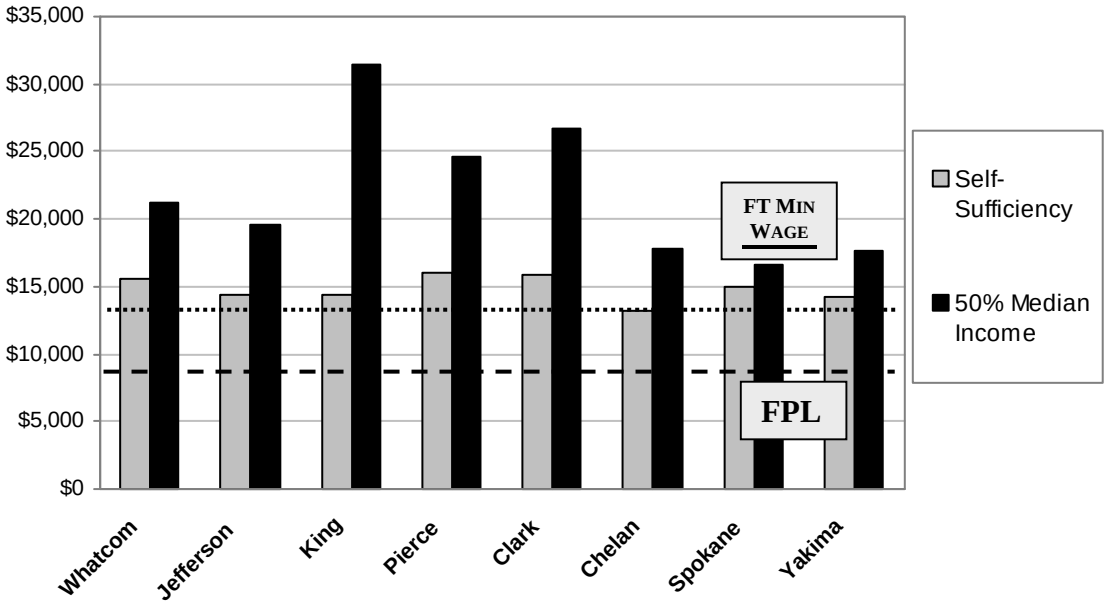
Note: A=Adult; I=Infant; P=Preschool age child
Source: 2001 Federal Poverty Guidelines (FPL) – http://aspe.hhs.gov/poverty/01poverty.htm; Median Income by County (2001 Forecast). http://www.ofm.wa.gov/poptrends/table16.pdf; Self-Sufficiency Standard for WA State, September 2001, by Diana Pearce, PhD.

Figures 5 through 7 illustrate the differences among all four measures for three family types across eight counties.[15] The Standard is higher than the full-time minimum wage except for single adult families in Chelan County, where the two measures are roughly the same. However, the full-time minimum wage is greater than FPL in all counties for all family types except single adults with dependents. The latter result is predictable given that FPL increases with family size whereas full-time minimum wage only increases with additional workers.

[15] Pearce's Self Sufficiency Standard used in Figures 5-7 is higher for King County than for Whatcom County, but the Adjusted Standard is sometimes higher for Whatcom County than for King County. This apparent anomaly is because the Self Sufficiency Standard is calculated for three sub-regions within King County (Seattle, Bellevue/Juanita/Kirkland/Redmond, and the balance of the county). The Standard in Figures 5-7 represents an amalgam of the entire county. However, we only calculated the Adjusted Standard for the Seattle sub-region recognizing that the uninsured population is concentrated in this area. In central King County (as opposed to the two other King County regions), Pearce's model assumes that families use public transportation at a cost of $45-$90 per month depending on family size, whereas families in the more rural Whatcom County, are assumed to use private transportation at a cost of $236-$416 per month, again depending on family size.

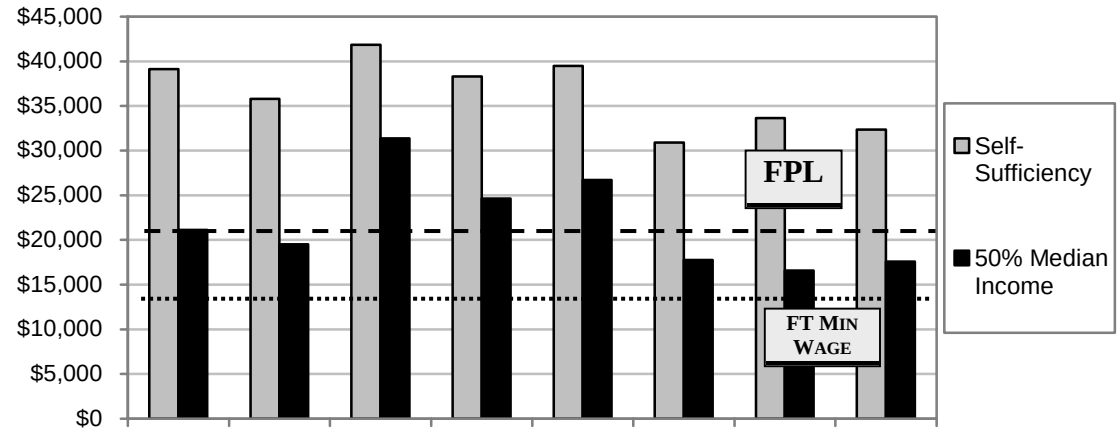
***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Figure 5. Comparison of Income Adequacy Measures: 1 Adult



Source: 2001 Federal Poverty Guidelines (FPL). http://aspe.hhs.gov/poverty/01poverty.htm (1/23/01); Median Income by County (2001 Forecast). http://www.ofm.wa.gov/poptrends/table16.pdf; Self-Sufficiency Standard for WA State, September 2001, by Diana Pearce, PhD.

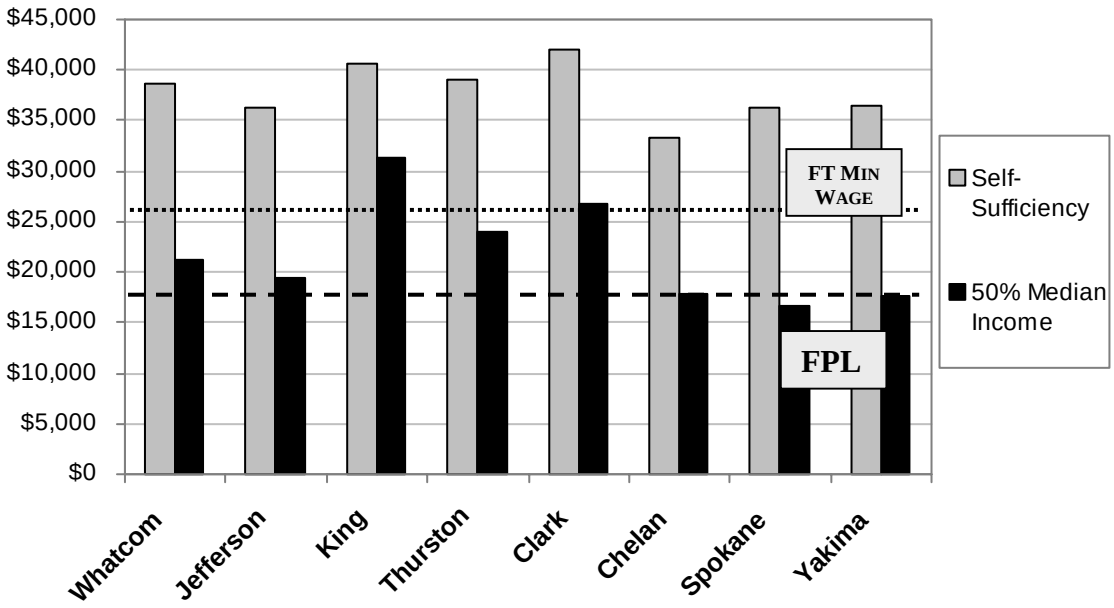
Figure 6. Comparison of Income Adequacy Measures: 1 Adult, 1 Infant, 1 Preschool-Aged Child



Source: 2001 Federal Poverty Guidelines (FPL). http://aspe.hhs.gov/poverty/01poverty.htm (1/23/01); Median Income by County (2001 Forecast). http://www.ofm.wa.gov/poptrends/table16.pdf; Self-Sufficiency Standard for WA State, September 2001, by Diana Pearce, PhD.

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Figure 7. Comparison of Income Adequacy Measures: 2 Adults, 1 Infant, 1 Preschool-Aged Child



Source: 2001 Federal Poverty Guidelines (FPL) – http://aspe.hhs.gov/poverty/01poverty.htm (1/23/01); Median Income by County (2001 Forecast). http://www.ofm.wa.gov/poptrends/table16.pdf; Self-Sufficiency Standard for WA State, September 2001, by Diana Pearce, PhD.

Based on these comparisons, we selected the Self-Sufficiency Standard as our measure of income adequacy for this report. We wanted a measure that allowed us to consider both income and expenses and one that accounted for differences in these components across both family types and geographic regions. The Standard is the single measure among the four for which this is true.

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Washington State Planning Grant on Access to Health Insurance

Private Insurance Carrier Questionnaire

Name of Payer: _____ Contact Person: _____ Title of Contact: _____

Telephone Number: _____ Fax Number: _____ Email Address: _____

1. Please provide the following information about your private clientele in the State of Washington.

	Private Products Your Organization Insures				Private Products Your Organization Administers Only			
	Individual	Small Group	Large Group Products		Individual	Small Group	Large Group Products	
	Products	Products	Insured	Self-Insured	Products	Products	Insured	Self-Insured
Number of private benefit packages or plan designs								
Number of plan sponsors*	N/A				N/A			
Number of subscribers								
Covered members								
With no other insurance								
With other insurance								
Total								
Names of largest private benefit package/plan sponsors	N/A				N/A			

* E.g., private employers

2. On what basis does your organization define a "plan" or "product" as separate from other plans or products? (*Please check all applicable responses.*)

- ☐ Unique benefit package
- ☐ Separate plan sponsor(s)
- ☐ Specific other features (e.g., access to restrictive provider networks in certain locations)
- ☐ Other (*Please specify.*)

3. What mechanisms does your organization use to identify different private plans? (*Please check all applicable responses.*)

- ☐ Unique plan identifiers (ID codes)
- ☐ Separate contracts
- ☐ Dedicated account representatives or teams
- ☐ Other (*Please specify.*)

4. What services are generally not included as covered benefits in private products? (*Please check all applicable responses.*)

Services Generally Not Covered (Excluded)	Indivi-dual	Small Group	Large Group Products	
	Products	Products	Insured	Self-Insured
Basic vision benefits				
Care provided by relatives or household members				
Care that is the responsibility of another party, or covered under workers compensation				
Governmental services or services covered by (other) governmental plans				
Cosmetic services				
Dental care				
Experimental services				
Infertility-related care				
Private nursing				
Rental or purchase of luxury durable medical equipment				
Special education				
Other (*Please specify*.)				

5. Please show the most common non-prescription drug benefit features included in your private plans:

	Individual Products			Small Group Products			Large Group Products					
							Insured			Self-Insured		
	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common
Deductibles												
Per individual	$	$	$	$	$	$	$	$	$	$	$	$
Per family	$	$	$	$	$	$	$	$	$	$	$	$
Coinsurance levels	%	%	%	%	%	%	%	%	%	%	%	%
Copays												
Office visit	$	$	$	$	$	$	$	$	$	$	$	$
Hospital admission	$	$	$	$	$	$	$	$	$	$	$	$
Other non-drug (*Please specify.*)	$	$	$	$	$	$	$	$	$	$	$	$
	$	$	$	$	$	$	$	$	$	$	$	$
	$	$	$	$	$	$	$	$	$	$	$	$
Internal plan limits on days, visits, procedures, dollars or other												
Mental health care	$	$	$	$	$	$	$	$	$	$	$	$
Chemical dependency care	$	$	$	$	$	$	$	$	$	$	$	$
Home health care	$	$	$	$	$	$	$	$	$	$	$	$
Skilled nursing facility care	$	$	$	$	$	$	$	$	$	$	$	$
Rehabilitation services	$	$	$	$	$	$	$	$	$	$	$	$
Other non-drug (*Please specify.*)	$	$	$	$	$	$	$	$	$	$	$	$
	$	$	$	$	$	$	$	$	$	$	$	$
Plan maximums (per lifetime)	$	$	$	$	$	$	$	$	$	$	$	$
Annual out-of-pocket limits												
Per individual	$	$	$	$	$	$	$	$	$	$	$	$
▪ Per family	$	$	$	$	$	$	$	$	$	$	$	$

6. What are your most frequent prescription drug cost-sharing approaches in private plans?

Private Plans	Individual Products		Small Group Products		Large Group Products			
					Insured		Self-Insured	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Five most common cost-sharing arrangements (indicate brand vs. generic; formulary vs. non-formulary)								
First								
Second								
Third								
Fourth								
Fifth								

7. What are your most frequent in- and out-of-network benefit differentials in private plans?

Private Plans	Individual Products		Small Group Products		Large Group Products			
					Insured		Self-Insured	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
A. Five most common coinsurance arrangements (*e.g., 90%/70%*)	*e.g., 90%*	*e.g., 70%*						
First								
Second								
Third								
Fourth								
Fifth								
B. Five most common copay arrangements (e.g., $10/$25)	*e.g., $10*	*e.g., $25*						
First								
Second								
Third								
Fourth								
Fifth								

8. Please outline your primary gatekeeper (utilization management) requirements, and the types of benefits affected. (*Please check all applicable items.*)

Private Plans	Individual Products	Small Group Products	Large Group Products	
	e.g., mandatory pre-admission certification		**Insured**	**Self-Insured** ***e.g., voluntary case management***
Hospitalization				
Selected diagnosis				
Selected treatment				
Non-formulary				
Other (*Please specify.*)				

9. With regard to your private group plans, please provide your minimum underwriting rules for insured groups.

Private Plans	Small Group (Insured)	Large Group (Insured)
Minimum number of hours employees must work to qualify for coverage	_____ hours per week	_____ hours per week
Minimum employer contribution toward employee coverage	_____ %	_____ %
Minimum employer contribution toward dependent coverage	_____ %	_____ %
Other (please summarize)		

10. What, if any are the major distinguishing features of private plans you offer in different parts of Washington?

Private Plans	Individual	Small Group	Large Group	
			Insured	**Self-Insured**
Northwest Washington				
Seattle Area				
Southwest Washington				
Northeast Washington				
Spokane Area				
Southeast Washington				

11. From your organization's perspective, what are the reasons certain features, and variations among them, become commonplace or unusual? (*1=most important reason, 2=second most important reason, etc.*)

- Insurance mandates _____
- Marketplace demands _____
- Ease in administration _____
- Ease in communicating _____
- Other (*Please specify.*) _____

We ask that you please forward the following with your completed questionnaire no later than November 16, 2001 to:

Florence Katz
William M. Mercer, Incorporated
600 University Street, Suite 3200
Seattle, WA 98101

- Sample plan element worksheet (listing of benefits) used by your underwriters and actuaries to price plans.
- Sample plan implementation worksheets used to define or program adjudication rules (both manual and automatic).
- A rate sheet and associated benefit summary for your *individual* market plan:
  - Of highest benefit value with significant enrollment
  - With the highest enrollment
  - Of lowest benefit value with significant enrollment.
- A rate sheet and associated benefit summary for your *small group* market plan:
  - Of highest benefit value with significant enrollment
  - With the highest enrollment
  - Of lowest benefit value with significant enrollment.

Thank you for your cooperation. If you have any questions, please contact Florence Katz at 206 808 8469 or florence.katz@us.wmmercer.com.

Washington State Planning Grant on Access to Health Insurance

Preliminary Summary of Responses to Private Insurance Carrier Questionnaire

(Excerpted from draft consultant report on Potential Policy Options for Enhancing Access to Health Insurance Coverage) *

About the Respondents

- Nine responses: 2 national carriers, 1 health care service contractor, 4 third party administrators (TPAs) for self-insured plans, 1 TPA/provider network; 1 health maintenance organization (HMO)
- Well over 14,500 plan sponsors represented (note: one major payer declined to provide this information)
- Over 875,000 subscribers and 1,850,000 members covered.

General Findings

- Relatively small number of plan designs offered, but there is a recognition that groups may have variations on these designs (note: one TPA indicated it administers 150 benefit packages [plan designs]). Plans/products are defined by having
    - differentiated benefit packages and plan sponsors
    - specific other features (special network, gatekeeper, or referral requirements)
    - different ID/plan codes, contracts; sometimes account representatives and structures
- Many organizations have difficulty providing counts of members with and without dual coverage
- Typical exclusions
    - cosmetic services
    - dental care
    - experimental care
    - family-provided services
    - government services
    - infertility care
    - luxury DME
    - private nursing
    - special education
    - workers compensation/third party liability
- Unweighted deductible, coinsurance and copayment amounts (generally listed in order of frequency within top three payer-specified amounts). Please note that these listings are based on small number of responses, and incomplete responses from some payers.
    - most common deductibles – individual
        - individual, insured plans $500, $1,000
        - small group, insured $500, $200
        - large group, insured $300, $20016
        - large group, self-insured $0, $200, $300[1]
    - most common deductibles –family
        - individual, insured plans $1,500, $3,000
        - small group, insured $600, $1,500
        - large group, insured $600

16 If POS plan, these deductibles would apply only to out-of-network services.

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

    - large group, self-insured $600, $300
- Coinsurance generally 80%/20% to 100%/0%, with 20% differential if PPO plan
- Copayments
  - office visits – $10, $15, $20
  - hospital admission – primarily $250 per admission or $100/per day for up to three days
  - emergency room visits – $50 or $75 per visit
- Benefit limits
  - mental health
    - outpatient – 10–50 visits, generally 20 visits
    - inpatient – 8–45 days, generally 30 days
  - chemical dependency
    - 30–60 days/visits
    - $10,000–$11,000 every two years (per WA State law)
  - home health care – 130 visits
  - skilled nursing facility
    - if defined by utilization, 30, 60 or 90 days per year
    - frequently only in lieu of hospitalization
  - rehabilitation
    - if defined by utilization, 60 days/visits or 90 days per year
    - if defined by payment, $1,500 per year for outpatient rehabilitation and $30,000 per condition
  - policy maximum – unlimited, $1,000,000, $2,000,000
- Annual out-of-pocket limited (in-network)
  - individual – $2,000, $1,000
  - family – $6,000, with range from $0 to $7,500
- Prescription drug cost sharing
  - little use of closed formularies
  - main generic copays – $5, $10, or $15
  - main formulary brand copays – $10 and $20
  - non-formulary brand copays – $25 or more
- Utilization management
  - still some focus on pre-admission certification and other inpatient review techniques
  - disease/case management
  - for drugs, voluntary formularies, step therapy requirements
- Underwriting requirements for groups (except for Taft-Hartley groups)
  - minimum hours – 17.5 hours per week (minimum); generally ranges from 17.5 to 30; Taft-Hartley groups may use monthly requirement
  - Employer contribution
    - for employees – 50% to 75%
    - for dependents – 0% or 50%

***** The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

APPENDIX III: SECTION 4 OPTIONS FOR EXPANDING COVERAGE

Washington State Planning Grant on Access to Health Insurance

Administrative Simplification - Interview Protocol for Initial Inventory of Efforts

1. Name of interviewee
2. Title and workplace
3. Organization re: Administrative Simplification
4. Role in Organization
5. Recommended alternative/additional contacts:
6. Identification of the administrative simplification initiative (Name or label to which it is referred)
7. Description of initiative
8. Other initiatives under discussion/needed/considered
9. Leader/lead organization
10. Participants in the initiative
11. Location or locations of the initiative (single site, multiple sites)
12. Time Frame of initiative
13. Problem initiative is designed to address
14. Expected impact
    a. Savings of time
    b. Savings of money
    c. Reduce duplication of resource use
    d. Overall return on investment
    e. Examples:
15. Intended assessment of the initiative
    a. Anecdotal
    b. Evidence-based
    c. By whom
        i. In-house
        ii. Outside
        iii. Formal
16. Barriers/constraints
    a. Government
        i. State
        ii. Federal
        iii. Other
    b. System-wide barriers
        i. Administrative infrastructure
    c. Money
17. State government role
    a. Current
    b. Potential
18. Follow-up opportunities
    a. Primary point of contact
    b. Meetings/forum
19. Overlaps with other initiatives
20. Category of administrative simplification – to be created from the results of the inventor

Project funded by the U.S. Department of Health & Human Services, Health Resources and Services Administration's Bureau of Professions State Planning Grant #1 P09 OA 00002-01

APPENDIX III: SECTION 5 CONSENSUS BUILDING STRATEGIES

Washington State Planning Grant on Access to Health Insurance

Guiding Principles

These guiding principles provide context for work conducted under the auspices of the state planning grant on access to health insurance. The bullets are not in any priority order.

In our approach to "doing the work of" the grant we are committed to:

- Seeking input and feedback in a low key but broadly inclusive manner
- Not advocating for any single approach
- Informing discussions through solid data and analysis
- Maintaining faith that there are good ideas yet to come
- Keeping expectations of the grant realistic – one step forward is one step better than nothing
- Doing work that is relevant for today's and tomorrow's circumstances
- Building on, being complementary to, and supporting efforts of others to address related issues
- Focusing our expertise and resources where they can be of greatest value
- Being informed and inspired by the experience and lessons of previous efforts
- Moving beyond "admiring" the problem

In researching options to address access, we are interested in ideas that:

- Include local / community control and accountability
- Seek to expand private/public partnerships
- Reduce existing system complexities
- Are incremental and focused, preferably within a context of longer-range solutions
- Maintain consumer protections and choice but allow for regulatory or statutory simplification
- Are voluntary and incentive-based
- Target specific barriers and gaps faced by specific groups
- Refocus, redirect, and maximize existing delivery and financial resources
- Retain valued aspects of the current delivery and financing systems
- Challenge historical and existing assumptions about programs and systems
- Assist in maintaining Washington's gains of the past

MAKING HEALTH CARE WORK FOR EVERYONE

Project funded by the U.S. Department of Health & Human Services, Health Resources and Services Administration's Bureau of Professions State Planning Grant #1 P09 OA 00002-01

Washington State Planning Grant on Access to Health Insurance

2001 WASHINGTON HEALTH LEGISLATIVE CONFERENCE

Civic Engagement and Health System Change:
The Power of People

Survey Results

Status of Health System in Washington State

Q1: The health system in Washington State does a good job meeting the health needs of its citizens.

- Agree strongly 0.7%
- Agree 24.9%
- Disagree 46.9%
- Disagree strongly 8.4%
- Not sure 19.1%

Q2: Of the problems listed below, what is the **single most pressing problem** in the health system, in your opinion? (Top 5 responses)

- Social and economic health disparities 17.2%
- Low Medicare/Medicaid payment rates to providers 16.1%
- Pressure on the state budget to cut publicly covered populations 12.1%
- The state's uninsured population 11.7%
- Other 10.6%

Health System Change

Respondents believe that the following variables can have great impact on the problem selected in Q2:

- Government 65.6%
- Private/public partnership 39.6%
- Health care marketplace 26.4%
- Individuals 21.6%

Power of the People- Direct Legislation

Q8: In general, voter approved initiatives reflect what most people want their government to do:

- Agree strongly 5.5%
- Agree 29.3%
- Disagree 37.0%
- Disagree strongly 11.7%
- Not sure 16.1%

Q9: The initiative process is a good way to set state policy:

- Agree strongly 1.8%
- Agree 5.9%
- Disagree 31.9%
- Disagree strongly 47.6%
- Not sure 12.5%

The "Public" in Public Policy

Q10: What should be the goal of public involvement activities?

- Educate public about trade-offs in setting health policy 78.8%
- Provide a way for decision makers to learn needs/desires of the electorate 62.6%
- Forge consensus about what should be done to improve the health system 49.5%

Q11: What types of civic engagement activities have you participated in during the last six months on your own personal time:

- Voted in an election 92.3%
- Donated time/effort to a civic or religious organization 70.3%
- Attended a public/community meeting 67.0%
- Written a letter/sent an e-mail/talked with an elected official 64.1%
- Donated money to a political cause 56.9%

Access to Health Insurance

Q12: In terms of improving access to health insurance, which reform proposals would be the most ***effective***?

- Create program of universal coverage for catastrophic or preventive care 44.0%
- Reform the insurance market 16.1%
- Broaden existing public program eligibility and/or financing 12.8%

Q13: Which proposals would be the most ***politically viable***?

- Provide new financial incentives for employers to help employees 22.7%
- Provide new financial incentives for individuals/families to purchase plans 18.7%
- Encourage development of new or maximize existing purchasing pools 18.0%

Q14: Which segments of the uninsured population should be targeted for help?

- All segments should be treated equally 34.1%
- Individuals working in low wage industries 30.1%
- Low income children 30.1%

Washington State Planning Grant on Access to Health Insurance
2001 Washington Health Legislative Conference
December 4, 2001

Session -- The State Planning Grant on Access: Can We Talk?

SMALL GROUP DISCUSSION GUIDELINES

1. Facilitator introduces him/herself
2. Group selects a spokesperson
3. Group members briefly scan lists of potential targeted groups of uninsured and potential improvement-to-access options.
4. Discussion begins (and ends).

OVERARCHING QUESTION

Where do we go from here to make inroads on improving access to coverage?

SPECIFIC DISCUSSION QUESTIONS

1. Which are the most viable options and highest priority groups of uninsured on which to focus?
2. Why? (What criteria should be used to decide on viable options? On top priority groups?)
3. Do the answers change if you think short-term (2002 through 2004) compared to long-term (2005 – 2010)?
4. What are / will be the issues and barriers to carrying through on the foci you have identified?
5. What single message sums up your group's thoughts regarding improving access to insurance coverage for Washingtonians?
6. What "lack of knowledge" made this a difficult discussion?

Handout materials provided during the workshop are available at:
http://www.ofm.wa.gov/accesshealth/conference/conference.htm

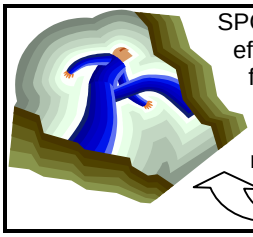
Project funded by the U.S. Department of Health & Human Services, Health Resources and Services Administration's Bureau of Professions State Planning Grant #1 P09 OA 00002-01

STATE PLANNING GRANT (SPG) ON ACCESS TO HEALTH INSURANCE OVERVIEW, January 15, 2002

SPG Accountable to Federal Government for:

1. Profile of Washington's uninsured
2. Options/strategies for improving access to affordable coverage and adequate benefits

Interim Report Due October 2001
Final Report Due March 2002



SPG + Communities: any single effort may represent small steps for small feet but collectively and eventually the efforts of many will turn into the **giant leap** needed for all

Washington SPG Research Work

- **Profiles** -- Detailed profiles of the uninsured population are being matched to detailed profiles of the current coverage and care pathways, including rigorous analysis of the gaps, overlaps and barriers.
- **Strategies** -- Analysis of the strengths and weaknesses of a universe of potential coverage and access options is being cross-walked to a similar analysis of strategies historically tried or in place in Washington (including, where appropriate and achievable, quantifiable impacts of strategies on specific uninsured and at-risk populations).
- **Linkages** -- Detailed assessment is being conducted of the links between identified gaps, overlaps, and barriers to coverage and care (in specific populations and circumstances) and the analysis of improvement strategies.
- **Individual Affordability** -- Significant energy is being devoted to understanding what individuals can afford to pay for coverage and care, compared to the reality of what's available to them. We consider this a "lynchpin" issue for crafting future coverage and access strategies.
- **System Affordability** -- Significant effort is also focused on administrative simplification strategies and partnerships, including options for reducing the currently complex array of insurance products (while still maintaining choice and variety). Creating a more affordable system via strategies that avoid unnecessary costs, reduce provider administrative burden, and set the stage for effective consumer-driven buying is directly relevant to improving access.
- **Community Partnerships** -- Building partnerships with community-based efforts and organizations addressing related issues is also a focus of our work. Mutual understanding of the issues faced, the solutions contemplated, and the flexibilities and accountabilities needed on all sides are part of this work.

Washington SPG Status

- **Deliverables** -- Working titles of deliverables to be received from consultant team by the end of February 2002 are:
  - Data for Assessing Access to Health Insurance in Washington
  - Profile of the Insured, Uninsured, and Insurance Affordability in Washington
  - Enhancing Access to Health Insurance Coverage and Health Care: Policy Options for WA State.
- **Time Extension** –Year extension (through February 2003) requested in January 2002. Initial funding period was March 01 – February 02. High likelihood of approval. No additional funding is available so actual work may not extend beyond June or July 2002.
- **Extension Activities**: Examples of activities include
  - Stakeholder input based on research findings provided by the consultants
  - Refined quantitative analysis of findings based on public input
  - Partnership building regarding coverage and simplification strategies

Visit us at: www.ofm.wa.gov/accesshealth/accesshealth.htm

Making Health Care Work for Everyone

Project funded by the U.S. Department of Health & Human Services, Health Resources and Services Administration's Bureau of Professions State Planning Grant #1 P09 OA 00002-01

Washington State Planning Grant on Access to Health Insurance

STAKEHOLDER WHO'S WHO

Management Oversight Panel and Governor's Sub-Cabinet on Health include representatives from:

- Department of Health
- Department of Social and Health Services – Medical Assistance Administration
- Health Care Authority
- Office of Financial Management
- Office of Insurance Commissioner
- State Board of Health

Stakeholders represent a broad range of organizations potentially interested in health care issues, including:

Accountable Care Technologies
Aetna Inc.
Alaska Air Group
Alliances Northwest
American Indian Health Commission
Associated Employers Trust
Association of Washington Business
Association of Washington Cities
Association of Washington Healthcare Plans
Basic Health Advisory Committee
Baldwin Resource Group
Ballard Chamber of Commerce
Boeing
Center for Medicaid and Medicare Services
CEO Forum
Children's Alliance
CHOICE Regional Health Network
CIELO
Coastal/Med/Grays Harbor Regional Health System
Columbia Legal Services
Community Choice PHCO: Provider Network
Community Health Plan of Washington
Community Innovations, Inc.
ComPASS
Coulee Community Hospital
D. Michener & Company
Deborah E. Peterman & Associates, Inc
Department of Corrections
Department of Health
Department of Labor & Industries
Department of Social & Health Services
Department of Veterans Affairs
Economic and Social Research Institute
Economic Opportunity Institute
Employer's Health Purchasing Co-op
Everett Clinic
Friends of Basic Health
Foundation for Health Care Quality
Freemont Public Association
GlaxoSmithKline
Grays Harbor County Social & Health Services Dept
Greater Seattle Chamber of Commerce
Group Health Cooperative of Puget Sound
Group Health Foundation
Harbor Pediatric Clinic
Health Care Authority
Health Commons
Health Improvement Partnership
Health Insurance Association of America
Health Resources & Services Administration
Hilke Faber and Associates
Human Links
IDX Systems Corporation
Immunex Corporation
Jamestown S'Klallam Tribe
Jefferson County Critical Access Project
Joe King & Associates
Johns-Brown Governmental Relations
Kaiser Foundation Health Plan of the Northwest
King County Health Action Plan
KMS Financial Services
Lehmann Wood & Associates
Liability Reform Coalition
Mark Reed Healthcare Clinic
Mark Reed Hospital
Mason General Hospital
Medical Assistance Administration
Microsoft
Molina Healthcare of Washington, Inc.
National Federation of Independent Business
NEWMG/Colville Medical Center
Nordstroms, Inc
Noridian Government Services
Northeast Washington Medical Group
Northwest Portland Area Indian Health Board
NW Strategies
Office of Financial Management
Office of the Attorney General
Office of the Insurance Commissioner
Olympia Family Medicine

Open Strategies
PACCAR, Inc
Pacific Public Affairs
PacifiCare of Washington
Peninsula Community Health Services
PHCO
Pike Market Medical Clinic
Pointshare
Premera Blue Cross
Providence Health Systems
Providence St. Peter Hospital
PROWest
Puget Sound Energy
RAND Corporation
Regence BlueShield
Rutgers University
SeaMar Community Health Center
Seattle Indian Health Board
Seattle King County Department of Public Health
Shelton Family Practice
Smith Kline Beecham
Sound Health Solutions
South Puget Intertribal Planning Agency
SPEEA
Spokane Tribe of Indians
Starbucks
State Board of Health
Stillaguamish Tribe
Swedish Health Services
Swedish Medical Center
Tacoma Pierce County Health Department
Terrill Lewis Wilke Insurance, Inc.
The Healthcare Decisions Group, LLC
The Meacham Group
The O'Connor Report
Thurston County Department of Public Health
University of Washington
Washington Association of Churches
Washington Association of Community and Migrant Health Centers
Washington Association of Counties
Washington Association of Health Underwriters
Washington Citizen Action
Washington Education Association
Washington Federation of State Employees
Washington Health Care Association
Washington Health Foundation
Washington Independent Business Association
Washington Policy Center
Washington Public Employees Association
Washington Rural Health Association
Washington State Congressional Delegation
Washington State Dental Association
Washington State Employment Security Dept
Washington State Hospital Association
Washington State Labor Council
Washington State Legislature
Washington State Medical Association
Washington State Nurses Association
Watson Wyatt Worldwide
Weyerhauser Company
William Meacham Insurance
William Mercer Inc.
WWAMI Center for Health Workforce Studies
Wyeth-Ayrst Laboratories
Yakima Chamber of Commerce
Yakima Medical Association
Yakima Valley Farm Workers Clinic

APPENDIX III: SECTION 6 LESSONS LEARNED AND RECOMMENDATIONS TO STATES

APPENDIX III: SECTION 7 RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

APPENDIX III: SECTION 8 DATA FOR ASSESSING ACCESS TO HEALTH INSURANCE

Washington State Planning Grant on Access to Health Insurance

Bibliography of Research Literature on Surveys of Health Coverage

(Excerpted from draft consultant report on Data for Assessing Access to Health Insurance in Washington State) *

Sources for Population-Based Surveys

Behavioral Risk Factor Surveillance System (BRFSS)

Broyles, R., McAuley, W., & Baird-Holmes, D. (1999) The medically vulnerable: their health risks, health status, and use of physician care. *Journal of Health Care for the Poor and Underserved, 10 (2),* 186-200.

Centers for Disease Control, United States Department of Health and Human Services. (2001). *Overview of the BRFSS system*. Retrieved August 28, 2001 at http://www.cdc.gov/nccdphp/brfss/.

Centers for Disease Control, United States Department of Health and Human Services. (2001). *List of BRFSS methodologic studies.* Retrieved August 28, 2001 at http://www.cdc.gov/nccdphp/brfss/pdf/mvr.pdf.

Medical Outcomes Trust Source. (1997). *Community and population studies-behavioral risk factor surveillance system (BRFSS).* Retrieved March 29, 2000 at www.outcomes-trust.org/sp97/cps3.htm.

Current Population Survey – March Supplement (CPS)

Bureau of the United States Census and Bureau of Labor Statistics, Joint Project. (2001). *Overview of the Current Population Survey*. Retrieved August 28, 2001 at http://www.bls.census.gov/cps/cpsmain.htm.

Bureau of the United States Census and Bureau of Labor Statistics, Joint Project. (2001). *Technical Paper 63, Current Population Survey: Design and Methodology*. Retrieved May 10, 2000 at http://www.census.gov/prod/2000pubs/tp63.pdf; retrieved May 10, 2000.

Bureau of the United States Census and Bureau of Labor Statistics, Joint Project. (2001). *Current Population Survey Data (Contact: cpshelp@info.census.gov CPS Help-Census/DSD/CPSB).* Retrieved May 1, 2000 at: http://www.bls.census.gov/cps/datamain.htm.

Bureau of the United States Census and Bureau of Labor Statistics, Joint Project. (2001). *The Current Population Survey (CPS) and State Health Insurance Coverage Estimates March 1, 2001.*

Bureau of the United States Census and Bureau of Labor Statistics, Joint Project. (2001). Impact of Changes to the Current Population Survey (CPS). State Health Insurance Coverage Estimate on March 1, 2001.

State Health Access Data Assistance Center (SHADAC), University of Minnesota. (2001). *SHADAC Technical Reports.* Retrieved August 30, 2001 at http://www.shadac.umn.edu/publications/pubs.htm.

State Health Insurance Coverage Estimates: Why State-Survey Estimates Differ from CPS 6/7/01

Census Publications on CPS:

Bureau of Labor Statistics. (2001, July). *The Employment Situation.* Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/empsit_jul2001.htm.

Bureau of Labor Statistics. (2001). Labor Force Status/Trends of Population Subgroups. *Veterans: Employment situation of Vietnam-era veterans.* Retrieved August 29, 2001 at *http://www.bls.census.gov/cps/pub/vet_1293.htm.*

Bureau of Labor Statistics, Division of Labor Force Statistics. (2001). *New Data on Contingent and Alternative Employment Examined by BLS.* Last revised: September 04, 1997. Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/conemp_0294.htm.

Bureau of Labor Statistics, Division of Labor Force Statistics. (2001). *BLS Union Members in 1997.* Last revised: February 2, 1998. Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/union_97.htm.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Bureau of Labor Statistics, Division of Labor Force Statistics. (2001). *BLS Union Members in 1996*. Last revised: January 31, 1997. Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/union_96.htm.

Bureau of Labor Statistics. (2001). *States and Regions: State and regional unemployment, 1995 Annual averages.* Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/srgune_1295.htm.

Bureau of United States Census. (1996, March). *Health Insurance Coverage*. Retrieved August 29, 2001 at http://ferret.bls.census.gov/macro/031996/health/toc.htm.

Bureau of United States Census. *Experimental Measures.* Retrieved August 29, 2001 at *http://www.bls.census.gov/cps/pub/pubexmth.htm. Retrieved August 29, 2001.*

Bureau of United States Census. (2001). Employment and Earnings. Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/pubee2.htm.

Bureau of United Census. (2001). *Educational Attainment of People 25 Years Old and Older, by Sex: March 1997.* Last revised: September 29, 1997. Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/1997/educ_att.htm.

Bureau of United States Census, Division of Labor Force Statistics. (2001). *Employee Tenure in the Mid-1990s*. Last revised: January 31, 1997. Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/tenure_0296.htm.

Bureau of United States Census and Bureau of Labor Statistics. (2001). *Country of Origin and Year of Entry into the U.S. of the Foreign Born, by Citizenship Status.* Source: March 1997. Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/1997/for_born.htm.

Bureau of United States Census and Bureau of Labor Statistics, Current Population Survey. (2001). *Geographical Mobility of People 1 Year Old and Older, by Sex, March 1996 and March 1997*. Source: March 1997. Retrieved August 29, 2001 at URL: http://www.bls.census.gov/cps/pub/1997/mobility.htm.

Bureau of United States Census and Bureau of Labor Statistics, Current Population Survey. (2001). *Selected Characteristics of the population by Hispanic origin.* Source: March 1997. Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/1997/int_hisp.htm.

Bureau of United States Census and Bureau of Labor Statistics, Current Population Survey. (2001). *Income Program Participation.* Retrieved August 29, 2001 at *http://www.bls.census.gov/cps/pub/pubincpp.htm.*

Bureau of United States Census and Bureau of Labor Statistics, Current Population Survey. (2001). *Labor Force Status/Trends of Population Subgroup. Blacks: A test of methods for collecting racial and ethnic information.* Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/ethnic_0595.htm.

Bureau of United States Census and Bureau of Labor Statistics, Current Population Survey. (2001). *Labor Force Status/Trends of Population Subgroups. Hispanics: A test of methods for collecting racial and ethnic information.* Retrieved August 29, 2001 at *http://www.bls.census.gov/cps/pub/ethnic_0595.htm.*

Bureau of United States Census and Bureau of Labor Statistics, Current Population Survey. (2001). *Person, Family and Household Characteristic. Employment Characteristics of Families: 1996.* Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/famee_0697.htm.

Bureau of United States Census and Bureau of Labor Statistics, Current Population Survey. (2001). *Person, Family and Household Characteristics. Households by Type: March 1997. Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/1997/hhldtype.htm.*

Bureau of United States Census and Bureau of Labor Statistics, Current Population Survey. (2001). *Person, Family and Household Characteristics. Marital status of people 19 years old and older, by sex: March 1997.* Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/1997/m_status.htm.

Bureau of United States Census and Bureau of Labor Statistics, Current Population Survey. (2001). *Race: Selected characteristics of the population by race: March 1997.* Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/1997/int_race.htm.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Bureau of United States Census and Bureau of Labor Statistics, Current Population Survey. (2001). *States and Metropolitan Areas. State and Metropolitan Area Employment and Unemployment: May 1996.* Retrieved August 29, 2001at http://www.bls.census.gov/cps/pub/laus_0596.htm.

Bureau of United States Census and Bureau of Labor Statistics, Current Population Survey. (2001). *States and Metropolitan Areas: Bureau of Labor Statistics Releases. 1992 Demographic book for states and large metropolitan areas. Retrieved August 29, 2001 at http://www.bls.census.gov/cps/pub/demdat_1292.htm.*

McKay, R. (2001). *Cognitive Research in Reducing Nonsampling Errors in the Current Population Survey Supplement on Race and Ethnicity*. Current Population Survey, a joint project of the Bureau of the United States Census and Bureau of Labor Statistics. Retrieved August 29, 2001 at http://www.bls.census.gov/cps/racethn/1995/statcanp.htm. Retrieved August 29, 2001.

Community Tracking Survey-Household Survey (CTS)

Center for Studying Health System Change, Community Tracking Survey. (2001). *Overview*. Retrieved August 28, 2001 at http://www.hschange.org/index.cgi?data=main.

Center for Studying Health System Change, Community Tracking Survey. (2000). Community Tracking Study Household Survey Instrument. Retrieved March 29, 2000 at http://www.hschange.com/tech4/tech4toc.html.

Center for Studying Health System Change. (2000). How well do communities perform on access to care for the uninsured? Retrieved April 4, 2000 at www.hschange.com/researcher/rr1_introduction.html.

Center for Studying Health Systems Change. (2000). Other key initiatives from the Robert Wood Johnson Foundation. Retrieved March 29, 2000 at www.rwjf.org/media/center1.htm.

Center for Studying Health System Change. (2001). *Community Tracking Study Household Survey: Instrument (Round One, Release 1) Technical Publication No. 04.* October 1997. Retrieved September 4, 2001 at http://www.hschange.org/CONTENT/160/.

Center for Studying Health System Change. (2001). *Community Tracking Study Household Survey: Interviewer Training Manual – Technical Publication No. 05.* June 1998. Retrieved September 4, 2001 at http://www.hschange.org/CONTENT/161/.

Center for Studying Health System Change. (2001). *Community Tracking Study Household Survey Public Use File: Users' Guide (Round One, Release 1) Technical Publication No. 07*. June 1998. Retrieved September 4, 2001 at http://www.hschange.org/CONTENT/163/.

Center for Studying Health System Change. (2001). *Community Tracking Study Household Survey Public Use File: Codebook (Round One, Release 1) Technical Publication No. 08.* June 1998. Retrieved September 4, 2001 at http://www.hschange.org/CONTENT/164/.

Center for Studying Health System Change. (2001). *Community Tracking Study Household Survey: Survey Methodology Report (Round One) Technical Publication No. 15*. November 1998. Retrieved September 4, 2001at http://www.hschange.org/CONTENT/171/.

Center for Studying Health System Change. (2001). *Community Tracking Study Household Survey Restricted Use File: Users' Guide – Technical Publication No. 17*. December 1999. Retrieved September 4, 2001 at http://www.hschange.org/CONTENT/173/.

Center for Studying Health System Change. (2001). *Community Tracking Study Household Survey Restricted Use File: Codebook – Technical Publication No. 18.* December 1999. Retrieved September 4, 2001 at http://www.hschange.org/CONTENT/174/.

Center for Studying Health System Change. (2001). *Community Tracking Study Household Survey Public Use File: Users' Guide – Technical Publication No. 21.* Summer 2001. Retrieved September 4, 2001 at http://www.hschange.org/CONTENT/351/.

Center for Studying Health System Change. (2001). *Community Tracking Study Household Survey Public Use File: Codebook (Round Two, Release 1) Technical Publication No. 22.* Summer 2001. Retrieved September 4, 2001 at http://www.hschange.org/CONTENT/352/.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Center for Studying Health System Change. (2001). *Community Tracking Study Household Survey Restricted Use File: Users' Guide (Round Two, Release 1) Technical Publication No. 23.* Summer 2001. Retrieved September 4, 2001 at http://www.hschange.org/CONTENT/353/.

Center for Studying Health System Change. (2001). *Community Tracking Study Household Survey Restricted Use File: Codebook (Round Two, Release 1) Technical Publication No. 24.* Summer 2001. Retrieved September 4, 2001 at http://www.hschange.org/CONTENT/354/.

Cunningham, P. (1999). Pressures on safety net access: The level of managed care penetration and uninsurance rates in a community. *Health Services Research 34(1)*, pp. 255-270.

Inter-University Consortium for Political and Social Research (ICPSR). Data can be retrieved at www.icpsr.umich.edu/archive1.html (select study number 2524).

Family Health Insurance Survey

Carlson, B.L. and KewalRamani, A. (1998). Survey design and data collection methodology for the Robert Wood Johnson Foundation's Washington State Follow-Up Study of the Uninsured. *Mathematica Policy Research Reference Number 8359-400*.

The Robert Wood Johnson Foundation Quarterly Newletter. (2000). State Health Reform: Problems and Challenges. Retrieved May 3, 2000 at www.rwjf.org/library/98issue3/ab3.htm; retrieved 5/03/00.

Medical Expenditure Panel Survey-Household Component (MEPS-HC)

Agency for Healthcare Research and Quality. (2001). *Overview of MEPS*. Retrieved August 28, 2001 at http://www.meps.ahrq.gov/whatis.htm.

Agency for Healthcare Research and Quality. (2001). *Sample Design of the 1996 Medical Expenditure Panel Survey Household Component. Methodology Report #2, 1997*. AHCPR Pub. No. 97-0027. Retrieved August 30, 2001 at http://www.meps.ahrq.gov/papers/mr2_97-0027/mr2.pdf.

Agency for Healthcare Research and Quality. (2001). *Sample Design of the 1997 Medical Expenditure Panel Survey Household Component. Methodology Report #11, 2000*. AHRQ Pub. No. 01-0001. Retrieved August 30, 2001 at http://www.meps.ahrq.gov/PAPERS/mr11_01-0001/mr11.pdf.

Agency for Healthcare Research and Quality. (2001). *Estimation Procedures in the 1996 Medical Expenditure Panel Survey Household Component. Methodology Report #5, 1999*. AHCPR Pub. No. 99-0027. Retrieved August 30, 2001 at http://www.meps.ahrq.gov/papers/mr5_99-0027/mr5.pdf.

National Health Interview Survey (NHIS)

Botman S.L., Moore T.F., Moriarity C.L., and Parsons V.L. (2001). Design and estimation for the National Health Interview Survey, 1995–2004. National Center for Health Statistics. *Vital Health Stat 2(130).* Retrieved September 6, 2001 at http://www.cdc.gov/nchs/data/series/sr_02/sr2_130.pdf.

Centers for Disease Control, National Center for Health Statistics. (2001). Overview. Retrieved September 6, 2001 at http://www.cdc.gov/nchs/nhis.htm.

Centers for Disease Control, National Center for Health Statistics. (2001). *Catalog of Electronic Products—National Health Interview Survey (NHIS) Public Use Data Files.* Retrieved April 19, 2000 at www.cdc.gov/nchs/products/catalogs/subject/nhis/nhis/htm.

Centers for Disease Control, National Center for Health Statistics. (2001). *National Health Interview Survey Instrument*. Retrieved April 19, 2000 at ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/1997/.

Centers for Disease Control, National Center for Health Statistics. (2001). *Surveys and Data Collection System.* Retrieved April 19, 2000 at ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Datasets/NHIS/1997.

Massey J.T., Moore T.F., Parsons V.L., Tadros W. (2001). Design and estimation for the National Health Interview Survey, 1985-94. National Center for Health Statistics. *Vital Health Stat 2(110).* Retrieved September 6, 2001 at http://www.cdc.gov/nchs/data/series/sr_02/sr2_110.pdf.

---

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

National Survey of American Families (NSAF)

Brick, J. M., Broene. P., Ferraro, D., Hankins, T., Strickler, T. (2000). No. 3: 1999 NSAF Sample Estimation Survey Weights. *The Urban Institute, Assessing the New Federalism*.

Brick, J. M., Broene. P., Ferraro, D., Hankins, T., Rauch, C., Strickler, T. (2000). No. 4: 1999 Variance Estimation. *The Urban Institute, Assessing the New Federalism.*

Brick, J.M., Broene, P., Cantor, D., Ferraro, D., Hankins, T., Rauch, C., and Strickler, T. (2000). No. 8: 1999 NSAF Response Rates and Methods Evaluation. *The Urban Institute, Assessing the New Federalism.*

Converse, N., Safir, A., Scheuren, F. (2001, July). No. 11: 1999 NSAF Public Use File Data Documentation. The Urban Institute, Assessing the New Federalism.

Cunningham, P., Brick, J.M., Meader, J. (2000, November). No. 5: 1999 NSAF In-Person Survey Methods. *The Urban Institute, Assessing the New Federalism.*

Dipko, S., Skinner, M., Vaden-Kiernan, N., Black, T., Coder, J., Converse, N., Cox, V., Lhila, A., and Scheuren, F. (2000). No. 10: 1999 NSAF Data Editing and Imputation. *The Urban Institute, Assessing the New Federalism.*

Judkins, D., Brick, J.M., Broene, P., Ferraro, D., and Strickler, T. (2001). *No. 2: 1999 NSAF Sample Design Report*. The Urban Institute, Assessing the New Federalism.

Kenney, G., Zukerman, S., Rajan, S., Brenner, N., & Holahan, J. (1999). The national survey of America's families: An overview of the health policy component. *Inquiry 36 (3)*, 353-362.

Rajan, S., Zuckerman, S., and Brennan, N. (1999, August). Verifying Insurance Coverage: Impact on Measuring the Uninsured with NSAF. *The Urban Institute, Assessing the New Federalism.*

Scheuren, F., Wang, K., Safir, A. (2001). No. 7: 1999 NSAF Collection of Papers. *The Urban Institute, Assessing the New Federalism.*

Urban Institute, National Survey of American Families. (2001). *Overview.* Retrieved August 28, 2001 at http://newfederalism.urban.org/nsaf/index.htm.

Urban Institute, National Survey of American Families. (2001). *Methodology Series. Can be retrieved at http://newfederalism.urban.org/nsaf/methodology1999.htm.*

Vaden-Kiernan, N., Cantor, D., Cunningham, P., Dipko, S., Malloy, K., Warren, P. (2000, November). *No. 9: 1999 NSAF Telephone Survey Methods.* The Urban Institute, Assessing the New Federalism.

Wang, K., Cantor, D., and Vaden-Kiernan, N. (2000, February). NSAF Questionnaire.

Survey of Income and Program Participation (SIPP)

Bureau of United States Census. (2001). *Overview*. Retrieved August 28, 2001 at http://www.sipp.census.gov/sipp/sippov98.htm.

The following reports are available at http://www.sipp.census.gov/sipp/pubsmain.htm:

Statistical Briefs :

Health Insurance Coverage: Who Had a Lapse Between 1990-92? (94-06)

Just What the Doctor Ordered (95-12)

Health Insurance Coverage: Who Had a Lapse Between 1991 - 1993? (95-21)

Getting A Helping Hand (95-27)

Mothers Who Receive WIC Benefits (95-29)

SIPP P-70 Reports:

Health Insurance Coverage 1986-88 (P70-17)

The Need for Personal Assistance with Everyday Activities (P70-19)

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

SIPP P-70 Reports:

Extended Measures of Well-Being-1984 (P70-26)

Who's Helping Out? Support Networks Among American Families:1988 (P70-28)

Health Insurance Coverage 1987-1990 (P70-29)

Americans with Disabilities: 1991-92 (P70-33)

Dynamics of Well-Being: Health Insurance, 1990-92 (P70-37)

Health Insurance, 1991-93 (P70-43)

The Effect of Health Insurance Coverage on Doctor and Hospital Visits: 1990 - 1992 (P70-44)

Beyond Poverty: Extended Measures of Well-Being - 1992 (P70-50)

Who Loses Coverage & for How Long? (P70-54)

Americans with Disabilities: 1994-95 (P70-61)

Who Loses Coverage, and For How Long? (P70-64)

Americans With Disabilities: 1997 (P70-73)

SIPP Working Papers:

Working Paper 182: The Effectiveness of Oversampling Low Income Households in SIPP

Working Paper 186: Cross-Sectional Imputation and Longitudinal Editing Procedures in the SIPP

Working Paper 199: Weighting Schemes for Household Panel Surveys

Working Paper 200: Weighting Adjustments for Panel Nonresponse in the SIPP

Working Paper 201: Overview of SIPP Nonresponse Research

Working Paper 203: The Redesign of the SIPP

Working Paper 204: Adjusting for Attrition in Event History Analysis

Working Paper 206: Nonresponse Research Plans for the SIPP

Working Paper 209: Continuing Research on Use of Administrative Data in SIPP Longitudinal Estimation

Working Paper 210: Overview of Redesign Methodology for the SIPP

Working Paper 211: Research on Characteristics of SIPP Nonrespondents Using IRS Data

Working Paper 212: The SIPP Cognitive Research Evaluation Experiment - Basic Results and Documentation

Working Paper 216: Compensating for Missing Wave Data in the SIPP

Working Paper 218: A Comparative Analysis of Health Insurance Coverage Estimates: Data from CPS and SIPP

Working Paper 226: Comparing Certain Effects of Redesign on Data from the SIPP

Working Paper 228: Developing Extended Measures of Well Being - Minimum Income and Subjective Income Assessments

Working Paper 229: Surveys On Call - On Line Access to Survey Data

Working Paper 230: SIPP Quality Profile, 1998 (in PDF format)

Working Paper 231: Preliminary Estimates on Caregiving from Wave 7 of The 1996 SIPP

Working Paper 232: The SIPP - Recent History and Future Developments

Working Paper 234: The Survey of Income and Program Participation (SIPP) Methods Panel Improving Income Measurement

---

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Additional reports: retrieved August 28, 2001 at http://www.sipp.census.gov/sipp/entirewa.pdf.

Washington State Population Survey (WSPS)

Washington State Office of Financial Management. (2001). Description of 2000 study. Retrieved August 28, 2001 at http://www.ofm.wa.gov/sps/2000/index.htm.

Washington State Office of Financial Management. (2001). *2000 Washington State Population Survey Data Dictionary (May 11, 2001 - Release 3).* Retrieved August 28, 2001 at http://www.ofm.wa.gov/sps/2000/dictionary.pdf.

Washington State Office of Financial Management. (2001). *2000 Data*. Retrieved August 28, 2001 at http://www.ofm.wa.gov/sps/2000/download.htm.

Washington State Office of Financial Management. (2001). *2000 Data tabulations*. Retrieved August 28, 2001 at http://www.ofm.wa.gov/sps/2000/tabulations.htm.

Washington State Office of Financial Management. (2001). Overview of the 1998 Washington State Population Survey. Retrieved August 22, 2001 at http://www.ofm.wa.gov/sps/index.htm.

Washington State Office of Financial Management. (2001). Washington State Population Survey Selected Findings. Retrieved August 28, 2001 at http://www.ofm.wa.gov/sps/1998/reports/part1.PDF.

1998 Technical Reports:

Washington State Office of Financial Management. (1999, January). *1998 Washington State Population Survey Technical Report #1: Sample Disposition and Response Rates.* Office of Financial Management Forecasting.

Washington State Office of Financial Management. (1999, January). *1998 Washington State Population Survey Technical Report #2: Weighting Procedure.* Office of Financial Management Forecasting.

Washington State Office of Financial Management. (1999, January). *1998 Washington State Population Survey Technical Report #3: Notes on Constructed Variables.* Office of Financial Management Forecasting.

Washington State Office of Financial Management. (1999, July). *1998 Washington State Population Survey Addendum to Technical Report #3: Notes on Constructed Variables*. Office of Financial Management Forecasting.

Research Briefs:

Washington State Office of Financial Management. (1999, April). *Characteristics of Households With and Without Telephones: Analysis with 1990 Census Data.* Retrieved August 28, 2001 at http://www.ofm.wa.gov/sps/briefs/brief1.pdf.

Washington State Office of Financial Management. (1999, June). *Washington State Population Survey Research Brief No. 2. Self-Reported Health Status: Social and Demographic Characteristics.* Retrieved August 28, 2001 at http://www.ofm.wa.gov/sps/briefs/brief2.pdf.

Washington State Office of Financial Management. (1999, June). *Washington State Population Survey Research Brief No. 3. Self-Reported Health Status: Social and Demographic Characteristics.* Retrieved August 28, 2001 at http://www.ofm.wa.gov/sps/briefs/brief3.pdf.

Washington State Office of Financial Management. (1999, May). *Washington State Population Survey Research Brief No. 4. Educational Attainment and Income for Persons and Households.* Retrieved August 28, 2001 at http://www.ofm.wa.gov/sps/briefs/brief4.pdf.

Washington State Office of Financial Management. (1999, June). *Washington State Population Survey Research Brief No. 5. Temporary and Part-Time Workers in Washington State.* Retrieved August 28, 2001 at http://www.ofm.wa.gov/sps/briefs/brief5.pdf.

Washington State Office of Financial Management. (1999, September). *Washington State Population Survey Research Brief No. 6. Health Insurance Coverage of Washington's Non-Elderly Population.* Retrieved August 28, 2001 at http://www.ofm.wa.gov/sps/briefs/brief6.pdf.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Washington State Office of Financial Management. (2000, March). *Washington State Population Survey Research Brief No. 7. Profile of Working Families with Children.* Retrieved August 28, 2001 at htttp://www.ofm.wa.gov/sps/briefs/brief7.pdf.

Other reports:

How new work arrangements are transforming Washington labor markets. Marc Baldwin,

Washington Senate Democratic Caucus. (1999, September). Retrieved August 28, 2001 at http://www.sdc.wa.gov/releases/shortterm.PDF.

Washington WorkFirst Survey (WWFS)

Burchfield, E. (2001). *Preliminary Reports 2000-Housing: Housing.* University of Washington, Daniel J. Evans School of Public Affairs. Retrieved September 5, 2001 at http://www.wa.gov/WORKFIRST/about/studyhous.pdf.

Klawitter, M.M. (2001). *Preliminary Reports 2000 – Job Characteristics: Families on and off TANF*. University of Washington, Daniel J. Evans School of Public Affairs. Retrieved September 5, 2001 at http://www.wa.gov/WORKFIRST/about/studyjobchar.pdf.

Klawitter, M.M. (2001). *Preliminary Reports 2000- Job Search Strategies and Outcomes.* University of Washington, Daniel J. Evans School of Public Affairs. Retrieved September 5, 2001 at http://www.wa.gov/WORKFIRST/about/studysearch.pdf.

Klawitter, M.M. (2001). *Preliminary Reports 2000- Parent and Child Health Insurance Coverage.* University of Washington, Daniel J. Evans School of Public Affairs. Retrieved September 5, 2001 at http://www.wa.gov/WORKFIRST/about/studyinsur.pdf.

Klawitter, M.M. and Burchfield, E. (2001). *Preliminary Reports 2000- Adult Health*. University of Washington, Daniel J. Evans School of Public Affairs. Retrieved September 5, 2001 at http://www.wa.gov/WORKFIRST/about/studyhealth.pdf.

Klawitter, M.M. Preliminary *Reports 2000- Welfare Patterns and Reasons.* University of Washington, Daniel J. Evans School of Public Affairs. Retrieved September 5, 2001 at http://www.wa.gov/WORKFIRST/about/studypatterns.pdf.

Klawitter, M.M. (2001). Final Reports 2001 – *Work First Study 3000 Washington Families: Employment*. University of Washington, Daniel J. Evans School of Public Affairs. Retrieved September 4, 2001 at http://www.wa.gov/WORKFIRST/about/STudyEmployment.pdf.

Klawitter, M.M. (2001). *Final Reports 2001 – Work First Study 3000 Washington Families: TANF Experience, exits and returns.* University of Washington, Daniel J. Evans School of Public Affairs. Retrieved September 4, 2001at http://www.wa.gov/WORKFIRST/about/StudyTANF.pdf.

Washington WorkFirst. (2001). *Description of study*. Retrieved August 22, 2001 at http://www.wa.gov/WORKFIRST/about/StudyIndex2.htm.

Washington WorkFirst. (2001, January). *WorkFirst Study Chart Book*. Retrieved August 22, 2001 at http://www.wa.gov/WORKFIRST/about/WFSChartBook.pdf. Other reports can be retrieved at *http://www.wa.gov/WORKFIRST/about/StudyIndex2.htm*.

Comparison of Population-Based Surveys

Bennefield, Robert. (1996, May). *Who Loses Coverage and for How Long?* Current Population Reports, P70-54. Washington, DC: Census Bureau.

Center for Studying Health System Change and Mathematica Policy Research, Inc. (1998). Estimates of Health Insurance Coverage in the Community Tracking Study and the Current Population Survey. Technical Publication 16. Can be retrieved at http://www.hschange.com/tech16/8525_toc.html.

Czajka, J. and Lewis, K. (1999, May). Using national survey data to analyze children's health insurance coverage: An assessment of issues. Retrieved August 30, 2001 at http://aspe.os.dhhs.gov/health/reports/Survey%20data.htm.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Department of Health and Social Services, Office of the Assistant Secretary of Planning and Evaluation. (2001). Understanding Estimates of the Uninsured: Putting the Differences in Context. Retrieved August 30, 2001 at http://aspe.os.dhhs.gov/health/reports/hiestimates.htm.

Fronstein, P. (September, 2000). Counting the uninsured: A comparison of national surveys. *Employee Benefit Research Group, Issue Brief Number 225*.

Lewis, K., Marilyn E., and Czajka, J. (1998, July). Counting the Uninsured: A Review of the Literature. The Urban Institute, Assessing the New Federalism, Occasional Paper Number 8. Can be retrieved from http://newfederalism.urban.org/html/occ8.htm.

Monheit, A. (1994). Underinsured Americans: A Review. *Ann. Rev. Public Health. Vol. 15*, pp. 461-85.

Nelson, C.T. and Mills, R.J. (2001, August). The March CPS health insurance verification question and its effect on estimates of the uninsured. *Bureau of the United States Census, Housing and Household Economic Statistics Division.* Retrieved August 31, 2001 at http://www.census.gov/hhes/hlthins/verif.html.

Project HOPE Center for Health Affairs, prepared for the California Health Care Foundation. (May, 2000). *Using existing data to track insurance and access to health care in California.*

Schwartz, K. (1986). Interpreting the estimates from four national surveys of the number of people without health insurance. *Journal of Economic and Social Measurement, vol. 14*, 1986, pp. 233-243.

Schwartz, K., and McBride, T.D. (1990, Fall). Spells without health insurance: Distributions of durations and their link to point-in-time estimates of the uninsured. *Inquiry, vol. 27, no.3*, pp.281-288.

Short, P.F. (working paper, 2001). *Counting and characterizing the uninsured*.

Sources for Employer-Based Surveys

Employer Health Insurance Survey (EHIS)

Inter-University Consortium for Political and Social Research. (2001). *Overview*. Retrieved August 30, 2001 at http://www.icpsr.umich.edu:8080/ABSTRACTS/02935.xml?format=ICPSR.

Long, S. H., and Marquis, M.S. (2001). *Robert Wood Johnson Foundation Employer Health Insurance Survey* [Community Tracking Study and State Initiatives in Health Care Reform Program], 1997 [Computer file]. *2nd ICPSR version*. Washington, DC: RAND Corporation [producer], 2000. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor].

Long, S.H., and Marquis, M.S. (1999, November/December). Comparing Employee Health Benefits in the Public and Private Sectors. *Health Affairs*, vol 18, pp. 183-193.

Marquis, M.S., and Long, S.H. (1999, November/December). Trends in Managed Care and Managed Competition, 1993-1997. *Health Affairs 18*, pp. 75-88.

Marquis, M.S., and Long, S.H. (2000, January/February). Who Helps Employers Design Their Health Insurance Benefits? *Health Affairs 19*, pp. 133-138.

Medical Expenditure Panel Survey- Insurance Component (MEPS-IC)

Agency for Health Care Research and Quality. (2001). *Overview*. Retrieved August 30, 2001 at http://www.meps.ahrq.gov/.

Sommers, J.P. (2000). Imputation of Employer Information for the 1996 Medical Expenditure Panel Survey Insurance Component: *Methodology Report #10"*. AHRQ Pub. No. 00-0039. Retrieved August 30, 2001 at http://www.meps.ahrq.gov/papers/mr6_99-0037/mr6.pdf.

Sommers J.P. (1999). Construction of Weights for the 1996 Medical Expenditure Panel Survey Insurance Component List Sample: *Methodology Report #8* AHCPR Pub. No. 00-0005. Retrieved August 30, 2001 at http://www.meps.ahrq.gov/papers/mr8_00-0005/mr8.pdf.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Sommers J.P. (1999). List Sample Design of the1996 Medical Expenditure Panel Survey Insurance Component: Methodology Report #6. AHCPR Pub. No. 99-0037. Retrieved August 30, 2001 at http://www.meps.ahrq.gov /papers/mr6_99-0037/mr6.pdf.

Comparison of Employer Based-Surveys

Hing, E; Poe, G., and Euller, R. (1999). The effect of methodological differences in two surveys' estimates of the percentage of employers' sponsoring health insurance. *Inquiry*, *36*, *2*, 212-220.

Zarkin, G. (1995). *Employment-Based Health Insurance: Implications of the Sampling Unit for Policy Analysis.* Research Triangle Park, NC: Research Triangle Institute.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Washington State Planning Grant on Access to Health Insurance

Overview of Existing Population-Based and Employer-Based Surveys Evaluated As Potential Data Sources for Washington's Research

(Excerpted from draft consultant report on Data for Assessing Access to Health Insurance Coverage in Washington State) *

Population-Based Surveys

Survey Name (Code)	Years Conducted (since 1990)	Sponsored By	Survey Design Features	Areas	Periodicity	Over-Sampled Populations	Public Use Data Available
Washington State Population Survey (WSPS)	1998, 2000 2002 (underway)	WA State Office of Financial Management	• Telephone survey of 6,726 Washington households in 2000; 7,279 Washington households in spring of 1998 • Non-institutionalized civilian population	WA and 8 sub-state areas	2 year intervals	Racial minority groups	Yes
Current Population Survey – March Supplement (CPS)	1990-on	Bureau of Labor Statistics and U.S. Census Bureau	• Personal and telephone interviews with 50,000 households nationally • Has been conducted for more than 50 years • Non-institutionalized civilian population	U.S., States, MSAs	Annual, each March	Hispanic households	Yes
Behavioral Risk Factor Surveillance System (BRFSS)	1994-present	Centers for Disease Control (CDC), U.S. Dept. of Health and Human Services	• State managed • Number of state stratified samples to allow regional estimates • 12,306 telephone interviews with monthly samples for all states (mean for states 237) • Allows examination of monthly trends • Representative of households with telephones • Non-institutionalized civilian population	U.S., States, some sub-state areas	Monthly		Yes

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Survey Name (Code)	Years Conducted (since 1990)	Sponsored By	Survey Design Features	Areas	Periodicity	Over-Sampled Populations	Public Use Data Available
Community Tracking Survey (CTS)	Household Surveys: 1996; 1998; 2000-1 data collection currently underway	Center for Studying Health Systems Change Robert Wood Johnson Foundation (RWJF)	• Primarily telephone interviews (with some in-person for families without telephones) of about 60,000 individuals in 33,000 families nationally • 12 sites randomly selected to serve as case study sites (n=300 each), 58 other communities • Families are defined as all individuals in a family that can be covered by a typical private health insurance policy (usually spouses and other dependents less than age 18). Questions were asked about all adults in the family as well as one randomly sampled child • Non-institutionalized civilian population	U.S. and 12 case study areas, including Seattle MSA	Two year intervals	"High need" individuals identified in the first round interview may be over-sampled in longitudinal sample	Yes
Robert Wood Johnson Foundation Family Health Insurance Survey (FHIS)	1993, 1997	The Robert Wood Johnson Foundation	• 1993: Telephone survey (in person interviews for those without telephones) in ten states with a total of 27,000 families. • 1997: Telephone survey (in person interviews for those without telephones) in WA State only plus a small in-person component • 5,322 families completed shorter version of interview, with data on health insurance coverage, employment and income, 2,537 completed full interview • Non-institutionalized civilian population for both years	1993 - 10 states including WA; 1997 WA only	Twice, but the 1997 survey instrument was slightly different	1993 over-sampled uninsured and Medicaid recipients; 1997 over-sampled uninsured, and Medicaid and BH enrollees	1993 yes. 1997 no. All data are available to WA State.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Survey Name (Code)	Years Conducted (since 1990)	Sponsored By	Survey Design Features	Areas	Periodicity	Over-Sampled Populations	Public Use Data Available
National Medical Expenditure Panel Survey-Household Component (MEPS-HC)	1996, 1997, 1998	Agency for Healthcare Research and Quality, National Center for Health Statistics/ U.S. Department of Health and Human Services	• In person interviews • Links its components to the National Health Interview Survey, which enhances the analytic capabilities of both surveys • 10,500 families and 24,000 individuals nationally • Six rounds of interviews over 2 years • Linked to survey of employers • Non-institutionalized civilian population	U.S. and regions	Annual	Policy relevant population subgroups, such as functionally impaired adults, children with activity limitations, expected high-cost individuals, expected low-income families, Hispanics and African Americans	Yes
National Health Interview Survey (NHIS)	1990-on; redesign in 1995	National Center for Health Statistics/ U.S. Department of Health and Human Services	• Continuing national survey utilizing a stratified multi-stage sample design • 36,000 to 47,000 households per year, including approximately 106,000 individuals nationally • Sample size is too small to support state estimates • Non-institutionalized civilian population	U.S. and regions	Annual	African Americans and Hispanics	Yes
National Survey of American Families (NSAF)	1997, 1999	Urban Institute (Assessing the New Federalism) *Consortium of private funders	• Household telephone surveys • Non-telephone households included • 13 states and national samples • Over 44,000 households yielding information on over 100,000 people across the 13 states • 5,757 adults in WA; additional sample of "most knowledgeable adult" for children • Non-institutionalized civilian population	U.S. and 13 states including WA	Two year intervals	Below 200% poverty line (18,000 households – 52% of target sample)	Yes

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Survey Name (Code)	Years Conducted (since 1990)	Sponsored By	Survey Design Features	Areas	Periodicity	Over-Sampled Populations	Public Use Data Available
National Survey of Income and Program Participation (SIPP)	1990-on; redesign in 1996	U.S. Census Bureau	• Continuous series of national panels • 14,000 to 36,700 interviewed households nationally to form nationally representative sample • Each respondent is interviewed once every four months for 2.5 years, providing longitudinal data • Interviews conducted in person and by telephone • All household members 15 and over are interviewed by self-response; proxies are used as needed • Non-institutionalized civilian population	U.S. and regions (limited state est. possible)	Ongoing		Yes

Employer-Based Surveys

Survey Name (Code)	Years Conducted (Since 1990)	Sponsored By	Survey Design	Area	Likelihood of study continuing	Periodicity	Data Availability
Robert Wood Johnson Foundation Employer Health Insurance Survey (EHIS)	1993, 1997	The Robert Wood Johnson Foundation	• Primarily telephone interviews with a national probability sample of private and public employers • Samples of private employers selected from Dun's Market Identifiers • Excludes self-employed persons with no employees; excludes federal employers in 1993 • Data regarding state employees were obtained from each state government • Data regarding federal employees taken from U.S. Bureau of Labor Statistics and Office of Personnel Management (1997 only) • 1993-For public employers, a sample frame of "purchasing" units constructed based on consultation with state and	1993 - 10 states including WA 1997 – CTS sites, U.S. and several states, including WA	Unlikely	Twice	Data are available on a public access file

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Survey Name (Code)	Years Conducted (Since 1990)	Sponsored By	Survey Design	Area	Likelihood of study continuing	Periodicity	Data Availability
			other government units • 1997-Local government sample drawn from the Census of Governments				
Medical Expenditure Panel Survey-Insurance Component (MEPS-IC)	1996 to present	Agency for Healthcare Research and Quality, U.S. Dept. of Health and Human Services	• For list sample: • Mail and telephone survey of business establishments and governments nationally • Nationally representative sample selected from the Census Bureau lists of business establishments and governmental units and IRS list of self employed persons • Follow-back (linked) sample of employers and other insurance providers of MEPS-HC participants Service list of the self-employed	Yes	Very likely	Annual	Some data are currently available for 1996-1998 studies Data are not available but sponsor provides detailed tables and responds to data requests, resources permitting

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Washington State Planning Grant on Access to Health Insurance

Factors Affecting the Precision of Survey Estimates: Sample Size and Design

(Excerpted from draft consultant report on Data for Assessing Access to Health Insurance Coverage in Washington State) *

Survey (Code)	Sample Design	Sample Size	Areas
WSPS	• Random digit dialing used to draw general population sample • General population sample is stratified into eight geographic regions (target for each region was 750 respondents) • Supplemental statewide samples of African Americans, Asians, Hispanics, and Native Americans were drawn from Census tracts containing the highest number of these groups	6,726 households in 2000	WA and 8 sub-state areas
CPS	• Multi-stage area-probability sampling • Panel design in which household is interviewed for 4 consecutive months, followed by an 8-month rest period, then interviewed for another four months • Replenish sample each month	64,990 households nationally	U.S., WA, other states (pooling years is recom-mended)
BRFSS	• Random digit dialing • Sampling strategy varies slightly from state to state.	More than 118,348 interviews nationally in 1998 In 2000, 3,584 interviews were conducted for WA	U.S., WA other states
CTS	• Random digit dialing • Includes a supplemental in-person sample to represent households without telephones • Nationally representative cross-sectional survey • Data are collected in 60 randomly selected communities nationwide • Twelve communities are selected to be case-study areas, including Seattle,	Nearly 33,000 families and over 60,000 individuals	U.S. and 12 case study areas, including Seattle MSA

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Survey (Code)	Sample Design	Sample Size	Areas
	WA.		
FHIS	• Random digit dialing • Supplemented by Medicaid and BH enrollee list samples • RDD sample was stratified based on geography and health insurance coverage, and uninsured were over-sampled • Included area probability sampling for non-phone households	Part 1: 5,322 families and 11,475 persons Part 2: 2537 families and 5871 persons	1993 covered 10 states including WA; 1997 covered only WA
MEPS-HC	• Multi-stage area probability sample • Rotating panel design; preliminary contact followed by six rounds of interviews over a 2 1/2 year period • New series launched each year to provide overlapping panels	Between 8,000 and 10,000 households per panel Every 5 years the sample size is increased	U.S. and regions
NHIS	• Multi-stage area probability sample	Approximately 43,000 households and 106,000 individuals	U.S. and regions
NSAF	• Random digit dialing • Included area probability sample of households without telephones	In 1999, 42,000 households and more than 109,000 non-elderly	U.S. and 13 states including WA
SIPP	• Multi-stage area probability sample • The duration of each panel ranges from 2 1/2 years to 4 years	14,000 to 36,700 interviewed households	U.S. and regions (limited state est. possible)

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Washington State Planning Grant on Access to Health Insurance

Population-Based Survey Support of Local Area Estimates

(Excerpted from draft consultant report on Data for Assessing Access to Health Insurance Coverage in Washington State) *

Survey	Geographic Areas			
	National	**Groups of States**	**Washington State**	**Sub-State Geographic Areas**
WSPS	No	No	Yes	Eight regions and the counties included in each: • **Clark**: Clark • **Other Puget Metro**: Kitsap, Pierce, Snohomish, Thurston; • **King**: King; • **Spokane**: Spokane; • **West Balance**: Clallam, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania, Wahkiakum; • **Yakima-Tri-Cities**: Benton, Walla Walla, Yakima; • **North Puget Sound**: Island, San Juan, Skagit, Whatcom; • **East Balance**: Adams, Asotin, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Stevens, Whitman..
CPS	Yes	U.S. Census Divisions and Regions	Yes[1]	Large Metropolitan Statistical Areas (MSAs), counties and cities[2]
BRFSS	Yes	Yes	Yes	Regions (estimates for children not supported)
CTS	Yes	No	No	Seattle and 11 non-Washington MSAs
FHIS	No	10 States	Yes	Multi-county areas by special arrangement[3]
MEPS-HC	Yes	U.S. Census Divisions and Regions	No	No
NHIS	Yes	U.S. Census Divisions and Regions	May be possible by special arrangement	No
NSAF	Yes	13 States	No	Multi-county areas by special arrangement[3]
SIPP	Yes	U.S. Census Divisions and Regions	Limited estimation possible[2]	No

[1] The Census Bureau recommends that state estimates be used with caution, as standard errors may be large. The Census Bureau published state estimates on a three-year average from the March CPS to create more stable estimates for making state-to-state comparisons.

[2] Estimates for these areas are possible, but may be unreliable due to large standard errors and sample design considerations. Estimates of common outcomes such as the proportion of persons with employer health insurance are more likely to be reliable than estimates of rare events (such as persons losing coverage after loss of a job).

[3] In principle, the sampling designs and sample sizes of these surveys permit estimation for multi-county sub-state areas. Sub-state identifiers are not available on public use data sets, but these might be available through special arrangement with survey sponsors.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Washington State Planning Grant on Access to Health Insurance

Potential Sources of Survey Bias in Population Surveys

(Excerpted from draft consultant report on Data for Assessing Access to Health Insurance Coverage in Washington State) *

Survey (Code)	Response Rate	Respondent Selection	Interview Mode
WSPS	2000: • 43% for general population • 29% for expanded sample 1998 • 59% for general population • 43% for expanded sample	MKA: Most knowledgeable adult is interviewee; responds for self and all other members of household	Telephone
CPS	93% overall (Fronstein, SHADAC) 80-82% completed the March supplement 43.2% in 1998 (Atrostic et al. 1999)	• MKA: Most knowledgeable adult is interviewee when possible; responds for self and all other members of household • If individual moves from household, they are dropped from sample	In person and by telephone, varies over the course of interviews
BRFSS	76.5% nationally	One adult (18+) is randomly selected from each household	Telephone
CTS	65% between 1996-1997 (Lewis et al., 1998)	• Individual adult responds for all household adult residents • In addition, respondent supplies information on one randomly selected child in household	Primarily telephone interviews; additional in person interviews for sample of households without telephone
FHIS	69.2% for RDD sample 42.9% for Medicaid sample 73.4% for BH list sample 51.5% for field sample	MKA: Most knowledgeable adult is interviewee; responds for self and all other members of the family insurance unit	Primarily telephone interviews; additional in person interviews for sample of households without telephone
MEPS-HC	65.2% for Panel 4 in early 2000	One family respondent reports for self and other family members	In person; except that initial contact is by mail and telephone and final interview is by telephone

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Survey (Code)	Response Rate	Respondent Selection	Interview Mode
NHIS	Reported as greater than 90% [National Center for Health Statistics (NCHS) Web site; http://www.cdc.gov/nchs/]	• For family core: All family members are invited to respond for themselves. For children and adults who are not at home, a responsible adult family member may respond • For adult core: One randomly selected adult responds for self (no proxies permitted) • For child core: MKA-- Most knowledgeable adult is interviewee; responds for self and all other members of household	In person
NSAF	Approximately 64% in 1999	MKA: Most knowledgeable adult is interviewee; responds for self and all other members of household	Telephone For those interviewees without telephones, in person interviewers provided respondents with cellular phones, and interviews were conducted via cell phones
SIPP	79.1% in 1998 (Atrostic et al. 1999)	• Interviews are conducted with all individuals aged 15 and older. Proxies are permitted when necessary • If individual moves from household, they are followed to new household, and new housemates are included in sample	In person, with follow-ups conducted over telephone

Potential sources of bias in population-based surveys available for analysis of health coverage in Washington State are summarized as follows for illustration only, showing the approximate relative level of each type of bias. Although BRFSS sampling frame coverage is likely be strong, its sample is not designed to cover the entire family (i.e. it does not include children) and is thus classified as having a high potential under-coverage bias.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Survey	Frame & Population Coverage	Response Rate	Respondent Selection	Interview Mode	Recall
WSPS	Medium	Medium	Medium	Low	Low
CPS	High	Very Low	Medium	Very Low	High
BRFSS	High	Low	Low	Low	Low
FHIS	Low	Low	Medium	Low	Low
NSAF	Low	Low	Medium	Low	Low

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Washington State Planning Grant on Access to Health Insurance

Work In Progress

(Excerpted from draft consultant report on Data for Assessing Access to Health Insurance Coverage in Washington State) *

Survey Content

All of the population surveys reviewed included the demographic information needed for coverage policy analysis. These include age, race, Hispanic ethnicity (some also include information about other ethnic groups), sex, and education. In addition, most of the surveys reviewed include detailed information about relationships among household members. Relationship information is needed to combine household members into families that might be considered eligible for coverage under a specific policy option. For example, most surveys ask about all persons in the household who are related to the respondent, but coverage eligibility may be limited to spouses and the children. This is true of all surveys except the BRFSS, which asks questions only about the respondent and doesn't permit analyses at the family level.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

a. Content of Population Health Coverage Surveys

	WSPS	CPS		BRFSS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP
Source of Coverage										
Covered by Employer or Union	X(62)	X(74)/X(82)/X(83)		X(5)	X(11)	X(18)		X(30/3)	X(E-1)	X(J6)
Purchased Health Plan	X(62)	X(74)/X(84)		X(5)	X(12)	X(18)		X(30)	X(E-2)	X(J6)
Medicare	X(62)	X(77)/X(84)		X(5)	X(13)	X(13)		X(30)	X(E-3)	X(J1)
Medicare supplemental policies or Medigap					X(33)			X(30)		
Type of Medicare coverage							*X(28-52)	X(30)		
In Medicare HMO							X(28-56)	X(31)		
CHAMPUS	X(62)	X(79)/X(84)		X(5)	X(15)	X(16)		X(30)	X(E-4)	X(J6)
TRICARE	X(62)			X(5)	X(15)			X(30)	X(E-4)	X(J6)
CHAMP-VA	X(62)	X(79)/X(84)		X(5)	X(15)	X(16)		X(30)	X(E-4)	X(J6)
VA/ Other Military Health Insurance	X(62)	X(79)/X(84)		X(5)	X(15)	X(16)		X(30)	X(E-4)	X(J6)
Indian Health Service	X(64)	X(79)/X(84)		X(5)	X(16)			X(30)	X(E-4)	
Medicaid	X(62)	X(78)/X(84)		X(5)	X(14)	X(14)		X(30)	X(E-5)	X(J10)
Medicaid and Medicare						X(3)				
State Specific Program	X(63)	X (80)			X(17)	X(15)		X(30)	X(E-5)	X(J10)
Washington Basic Health Plan	*X(63)*	X(81)*but not on 2000 questionnaire??								
Healthy Options	*X(63)*									
DSHS Medical Assistance Programs	X(62)									
Covered by another source of insurance	X(63)					X(22)			X(E-13)	
Other government health care		X(82)								

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Content of Population Health Coverage Surveys (continued)

	WSPS	CPS		BRFSS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP
Extended through COBRA							*X(28-192)			
Covered as a temporary worker	X(21)									
Covered by former employer										X(J6)
Covered by spouse's employer or union										
Covered by someone not living in household	X(63)	X(76)		X(5)	X(13)					X(J7)

NOTE: An X denotes that the item appears on the survey. The number in parentheses represents the page on which the item can be found.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Content of Population Health Coverage Surveys (continued)

	WSPS	CPS	BRFSS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP
EMPLOYMENT AND FINANCES									
Employment									
Current work status	X(15)	(X41BMS)	X(26)	X(96)	X(48)	X	X(FC47)	X(I1)	X(D31)
Past year work status	X(24)	X(4)			X(55)	X	X(FC48)	X(I13)	X(D1)
Current full time/part time/temporary	X(16)	(X41BMS)		X(97)	X(49)	X		X(I7)	X(D16)
Past year full-time/part-time/temporary	X(24)					X		X(I7)	
Job changes in past year	X					X			
Temporary, part time, or seasonal work in [year]	X(20)	X(4)			X(49)				X(D30)
Number of weeks worked in [reference period]	X(24)	X(5)			X(55-A)	X	X(FC48)		X(D25)
For how many employers did you work in [year]/ how many businesses owned? (If more than one at one time, count as one)	X(16)	X(6)				X			X(D5)
Number hours worked in last week		X(44BMS)			X(49)	X	X(FC47)	X(I7)	
Number hours usually worked per week	X(16)/X(18)	X(6)		X(97)	X(52)	X	X(FC47)	X(I7-17)	X(D16)
Want to work full time at 35 or more hours per week	X(19)	X(43BMS)							
Type of work	X(17)	X(8)				X		X(I3)	X(D15)
Most important/usual work activities or duties	X(17)	X(8)							
member of a union	X(21)					X			X(D17)

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Content of Population Health Coverage Surveys (continued)

	WSPS	CPS		BRFSS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP
EMPLOYMENT AND FINANCES										
Employer Info										
Type of industry or business	X(17)	X(8)			X(100)	X(49)	X		X(I3)	X(D14-19)
private company	X(17)	(X61BMS)			X(97)	X(49)			X(I3)	X(D14)
government	X(17)	(X61BMS)			X(97)	X			X(I3)	X(D14)
federal gov't		(X61BMS)			X(97)	X(49)				X(D14)
state gov't		(X61BMS)			X(97)	X(49)				X(D14)
local gov't		(X61BMS)			X(97)	X(49)				X(D14)
self-employed	X(17)	(X61BMS)			X(96)	X(49)	X		X(I2)	X(D9)
non-profit	X(17)	(X61BMS)							X(I3)	X(D14)
working in family business	X(17)	(X61BMS)			X(97)				X(I3)	
own or operate a farm or business other than a farm	X(14)				X(97)	X(50)			X(I3)	X(D14)
Total number of persons employed in location where respondent works					X(98)	X(50-A)	X		X(I4)	
Employer has more than one location					X(99)	X(50-A)				X(D18)
Total number of persons who work for employer (in all locations)	X(18)	X(9)			X(99)	X(50-A)	X?			X(D18)
For those people who report some unemployment										
Has unemployed person been looking for work	X(22) past 4 weeks	X(4)				X(49) in past 4 weeks			X(I11)	X(D4)
How many weeks been looking for work	X(22)	X(4)								X(D4)
Main reason didn't work in [year/reference period]	X(16)	X(4)					X		X(I2)	X(D2)
Main reason left last job	X(24)	X(57BMS)								
Business/Industry of last job	X(24)									

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Content of Population Health Coverage Surveys (continued)

	WSPS	CPS	BRFSS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP
EMPLOYMENT AND FINANCES									
Income									
combined family or household income	X(41)	X(3)	X(26)	X(105)	X(57)	X	X(FC47)	X(I8/I21)	X(H)
Amount individual earned from all sources		X(65)		X(100)	X(56)	X	X(FC47)	X(I9)	X(H)
Amount individual earned from own business or farm		X(65)			X(56)		X(FC50)		X(H)
Amount earned from this employer during [time frame] (before taxes and other deductions)	X(17)	X(10)/year			X(53)	X		X(I9)	X(H)
Received Social Security or SSI payments during [year]	X(42)	X(20)			X(60)		X(FC50)	X(J2)	X(F2)
Amount of Social Security payments	X(42)	X(20)			X(60)			(XJ13)	X(H)
Received public assistance or Welfare payments	X(49)	X(33)			X(61)		X(FC52)	X(J1)	X(F6)
Amount of Welfare in [time period]	X(49)	X(35)			X(61)			X(J5)	X(G8)
Received Veteran's payments		X(36)					X(FC52)	X(J2)	X(F5)
Amount of Veteran's payments received		X(38)						X(J12)	X(H)
Received food stamps	X(48)				X961)	X	X(FC52)authorized to receive	X(J2)	X(G18)
Value of food stamps received	X(48)				X(61)			X(J8)	X(G24)
Other income by source	X(18)	X[13 -19]			X(58,59,62)		X(FC52)	X(J3)	X(D,F,G)
Assets									
Any questions about assets	X(46)	X(54)				X		X(J15)	X(I)
Amount of assets in total	X(46)	X(55)				X		X(J15)	X(I)
Amount of assets by source	X(46)	X(54)				X		X(J15)	X(I)

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Content of Population Health Coverage Surveys (continued)

	WSPS	CPS*	BRFSS	CTS	FHIS	MEPS**	NHIS	NSAF	SIPP
DEMOGRAPHICS AND PERSONAL VARIABLES									
Demographics									
Age	X(5)	X	X(24)	X(6)	X(8)	X	X(HC2)	X(SC3)	X(C9)
Race	X(6)	X	X(24)	X(106)	X(67)	X	X(HC2)	X(O1)	X(C15)
Of Spanish/Hispanic/Latino origin	X(5)	X	X(24)	X(6/106)	X(66)	X	X(HC2)	X(O1)	X(C15)
Gender	X(5)	X	X(28)	X(5)	X(8)	X	X(HC2)	X(SC3)	X(C2)
Education	X(7)	X	X(25)	X(5)	X(66)	X		X(L1)	X(C12)
Currently a student	X(22)	X(M75)		X(5)	X(8)	X			X(L1)
U.S. citizen	X(7)	X			X(66)		X(FC46)	X(O1)	
Family Relationship									
Total number of people residing in household	X(3)	X	X	X(3)	X	X	X(FC11)	X(SC2)	X(C2)
Number of adults in household	X	X	X(2)	X	X(10)	X	X(FC11)	X(SC3)	X(C2)
Number of children in household	X	X	X(25)	X	X(10)	X	X(FC11)	X(SC3)	X(C2)
Name of all householders	X(4)	X		X(3)	X(7)	X	X(HC2)	X(SC3)	X(C2)
Relationship of householders to all other householders	X(4)	X		X(7)	X(9)	X	X(HC8)		X(C4)
Parent or guardian of anyone in house		X		X(9)	X(11)	X	X(HC8)	X(SC4)	X(C5)
Marital Status	X(6)	X	X(25)	X(8)	X(10)	X	X(HC5)		X(C11)
Married to anyone in the household		X		X(8)	X(10)	X	X(HC5)		X(C5)
To whom married		X		X(8)	X(10)	X	X(HC5)		X(C5)
Telephone									
Number of telephones in household			X(27)	X(109)				X(M6)	
Alternate phone number listed or not		X(77)			X(69)				
Household been without telephone in past year				X(109)				X(M6)	
Length of time without telephone								X(M6)	

*CPS demographic variables may not appear on the March Supplement although the variables are available from other waves of the survey.

** MEPS-HC survey items with demographics were not available.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

b. Content of Employer Health Coverage Surveys

	MEPS-IC	EHIS	
	Page	Section	Page
COMPANY SIZE/# EMPLOYEES			
Company overall/Firm			
# of locations		A	2
# of employees nationwide	5	A	2-3
# of employees in state		A	3
Company at this location/Establishment			
# active employees		A	4
# permanent/temporary employees		A	6-7
# union members	5	A	8
# company retirees 65 or over	5	A	9
INSURANCE COVERAGE			
Does employer provide insurance?	1	A	12-14
Does company make available or contribute to the cost of any health insurance plans for employees or retirees?	1	A	I-40
Years company provided/contributed to health insurance		A	10
Company ever denied coverage?		A	10
Employee Eligibility:			
Waiting period for new employees (length of period)	4	A	10-11
Hours for insurance eligibility?		A	11
Number employees eligible for insurance	5	A	12-13
Full Time/Part Time	5		
Temporary or Seasonal Employee eligibility	5	A	12-13
Retiree eligibility (other than through COBRA)		A	12-13
How Insurance Purchased:			
Is insurance purchased through alliance/associations	2	A	14
Features of cooperative/alliance		A	15
Does company or employees select plans?			
Did company consult agent or broker to evaluate benefits?		A	15
Did broker give information on plans not associated with cooperative/ alliance?		A	15
Premium quotes outside of cooperative/alliance		A	16-17
Plans offered to employees at this location:			
Number of plans offered to employees	Inferred	A	21-23
Plan choice same as last year?		A	24
All plans administered by same company?		A	24
Plan administrator requires only its plans be offered?		A	25
Plan enrollment:			
Month plan year begins	2	A	25
Open enrollment period		A	25-26
Enrollments in all plans		A	26-30

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Content of Employer Health Coverage Surveys (continued)

	MEPS-IC	EHIS	
	Page	Section	Page
Cost:			
Annual cost of coverage plans offered *at this location*	4		
Employer contribution policy for health insurance		A	31
Amount spent for insurance in most recent year		A	32-35
Percent employer contributions to retirees' premiums		A	35
Increase or decrease in cost from last year		A	36
Plan Selection Decisions:			
Who makes decisions		A	36-37
Performance measures		A	37
Evaluation materials to employees		A	38
SPECIFIC PLAN INFORMATION; Asked for each plan		C	1-53
Type of plan			
Name of plan	2	C	15-18
Name of insurance carrier	2	C	15-18
Type of insurance plan	2	C	3-7
Self or fully insured	2	C	14-18
If self-insured plan:			
Self-administered or administered by third party?	2		
Stop loss policy?	2	C	19
Type and amount of stop loss		C	19-21
Number of enrollees covered by stop loss		C	21
Enrollees in plan	3	C	8-13
# enrollees excluding dependents	3	X	
# active employees enrolled	3	C	8
# former employees enrolled through COBRA	3	C	9
# retirees enrolled	3	C	10
# enrollees with single coverage	3	X	
Premiums and Employer/Employee Contributions:			
For self-insured plan:			
COBRA premiums: single and family of four	2	C	32-34
During most recent reporting period, actual paid claims, administrative costs, stop loss costs	2	C	35-36
Total number of enrollments		C	36
Premium equivalent calculated?		C	36-37

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Content of Employer Health Coverage Surveys (continued)

	MEPS-IC	EHIS	
	Page	Section	Page
For fully insured plans and self-insured plans with premium equivalent:			
Premium/premium equivalent for **employee-only** coverage employer contribution;	3	C	38-41
employee contribution for employee only coverage	3		
Premium/premium equivalent for **family** coverage employer contribution	3	C	42-46
employee contribution for family coverage	3		
Is premium/premium equivalent same for retirees 65+	3	C	41
Did premiums differ by:			
age	3	C	40
sex	3	C	40
number of persons (within family coverage)	3	C	42
wage or salary levels	3		
other	3		
Did amount of employee contribution differ by:			
employee categories (e.g., full-time, part-time,retiree)	3		
age		C	40
wage or salary levels		C	40
Plan Administrator		C	22
Insurance plan benefits:			
Require primary care physician **referral** to specialist	2	C	6?
Exclusion for **pre-existing conditions**?	4	C	22-23
Did exclusion for pre-existing conditions happen in [year of survey]	4	C	23
Waiting period for pre-existing conditions	4	C	23
Deductibles			
Total individual and family annual deductible	3	C	24-27
Deductible for physican care (answer this and hospital care if not answered total annual deductible)	3	C	24
Deductible for hospital care	3	C	24/27
Family deductible met if a number of individuals met their individual deductibles	3		

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Content of Employer Health Coverage Surveys (continued)

	MEPS-IC	EHIS	
	Page	Section	Page
Coinsurance/copayments		C	28-31
Enrollee cost for an overnight hospital stay ($ or %)	3	C	30-31
Enrollee cost for an office visit ($ or %)	3	C	28
Annual individual out-of-pocket limit	4	C	31-32
Annual family out-of-pocket limit	4		
Annual maximum plan would pay for individual; lifetime and one year?	3		
Any enrollee receive a direct subsidy or contribution (e.g., from a union or government)?	2		
Premium includes **life insurance**	3		
Premium includes **disability insurance**	3		
Services included in plan:			
100% well-baby care	4		
Adult immunizations	4		
Adult routine physical exams	4		
Alcohol/substance abuse treatment	4		
Child immunizations	4		
Chiropractic care	4		
Home health care	4		
Inpatient hospital stays		C	7
Inpatient mental illness	4		
Nursing home care	4		
Mental health		C	7
Office visits for prenatal care	4		
Orthodontic care	4	C	7
Other non-physician providers	4		
Outpatient mental illness	4		
Outpatient prescriptions	4	C	7
Physician services		C	7
Routine dental care	4	C	7
Routine mammograms	4		
Routine pap smears	4		
Vision care		C	7
Well child-care, 1-4 years	4		
Well-baby care, under 1 year	4		

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Content of Employer Health Coverage Surveys (continued)

	MEPS-IC	EHIS	
	Page	Section	Page
Offer optional coverage at additional premium:	4		
dental	4		
vision	4		
prescription drugs	4		
long-term care	4		
Total amount paid for these services	4		
Contract specifications			
For employers with fewer than 50 employees (in state):			
Guaranteed renewal of contract		C	47
Minimum employer contribution?		C	47
Minimum percent of employees must enroll?		C	47
Employees report prior history		C	48
For self-insured plans:			
Contract directly with physician groups or hospitals		C	48
Carve outs		C	48
How single service and general plans are "packaged":		C	52-53
Plan still offered in subsequent year?	4		
Plan replaced?	4		
If replaced, for replacement plan, what were:	4		
Single enrollment	4		
Family enrollment	4		
Single premium	4		
Family premium	4		
For companies that have pooled purchasing arrangement, is THIS plan:			
Purchased through cooperative/alliance?		C	1
Purchased through a business coalition?		C	1
Purchased through a MEWA or MET?	2	C	2
Sponsored by trade or professional association	2	C	2
Sponsored by a union?	2	C	2

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Content of Employer Health Coverage Surveys (continued)

	MEPS-IC	EHIS	
	Page	Section	Page
ESTABLISHMENT AND EMPLOYEE CHARACTERISTICS			
Length company in business	5	D	1
Industry	5	D	2-6
Ownership type	5		
For profit vs. non-profit	5		
Number of employees on payroll	5	D	7
full-time	5	X	
part-time	5	X	
temporary/seasonal employees	5	X	
Number of full- and part-time employees added to payroll in prior year		D	8
Number of permanent employees removed from payroll in past year		D	8-9
Distribution of hours permanent employees work		D	9
Number of hours/week must work to be full-time	5		
Age distribution for permanent employees		D	10
Number of employees over 50	5		
Percent of permanent female employees	(# of women)	D	11
Number of wage vs salary workers		D	11
Wage distribution for hourly workers	5	D	12
Earnings distribution for salaried workers		D	13-14
Gross amount of payroll		D	15
Number of labor hours included in payroll		D	15
Total sick days during most recent fiscal year		D	16
Fringe benefits offered			
Paid vacation	5		
Paid sick leave	5		
Life insurance	5		
Disability insurance	5		
Retirement/pension plans	5		
MSAs	5		
Flexible spending accounts	5		
Cafeteria plan	5		

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Content of Employer Health Coverage Surveys (continued)

	MEPS-IC	EHIS	
	Page	Section	Page
Eligible/Enrolled by Plan			
Total number of employees eligible	5	C	8
full-time	5		
part-time	5		
temporary/seasonal employees	5		
Total number of employees enrolled	5	C	8
full-time	5		
part-time	5		
temporary/seasonal employees	5		
FIRMS THAT DO NOT OFFER HEALTH INSURANCE			
Alternative company health care expense assistance:			
Payment for insurance under spouse's plan		B	1
Voucher or money to purchase health insurance	6	B	1
used for health insurance/health care only	6		
average per employee value of voucher	6		
Direct payment of medical bills	6	B	1
Prior insurance purchase:			
Ever denied health insurance?		B	2
Health insurance offered within past two years?		B	2
Health insurance offered since 1991	6		
Year last offered insurance	6		
If no: Company looked into purchasing insurance?		B	2
Premium quote within past two years?		B	3
Type of plan/s for which received quote		B	4
Lowest quote per employee		B	4-8

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

c. Availability of Data on Health Status, Utilization and Access to Care

	WSPS	CPS	BRFSS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP
Dimensions of Health Status									
Self-Assessed general health	X	X	X	X	X	X	X	X	X
Activity limitation/ Disability	X		X	X	X	X	X	X	X
Other			X	X		X	X	X	
Dimensions of Utilization									
Doctor Visits			X	X	X	X	X	X	X
ER Visits			X	X	X	X	X	X	
Inpatient				X	X	X	X	X	X
Preventive services			X	X	X	X		X	X
Other			X	X	X	X	X	X	X
Dimensions of Access to Care									
Usual Source of Care –Type of Place			X	X	X	X	X	X	
Usual Source of Care – Particular Physician			X	X		X			
Perceived barriers to Care/Unmet Need			X	X	X	X	X	X	X
Satisfaction with Care			X	X	X	X		X	

d. Availability of Economic Information

	WSPS	CPS	BRFSS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP
Employment									
Current Work Status	X	X	X	X	X	X	X	X	X
Past Year Work Status	X	X			X	X	X	X	X
Current full time/part time/temporary	X	X		X	X	X		X	X
Number hours usually worked per week	X	X		X	X	X	X	X	X
Type of industry or business	X	X		X	X	X		X	X
For those people who report some unemployment									
Has unemployed person been looking for work	X	X			X			X	X
Income									
Combined family or household income	X	X	X	X	X	X	X	X	X
Received Social Security or SSI payments	X	X			X		X	X	X
Received public assistance or Welfar Payments	X	X			X		X	X	X
Received Veteran's Paymnets		X					X	X	X
Assets									
Any questions about assets	X	X				X		X	X

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Washington State Planning Grant on Access to Health Insurance

Reasons for Differences in Survey Estimates of Washington's Uninsured Population

(Excerpted from draft consultant report on Data for Assessing Access to Health Insurance Coverage in Washington State) *

Tables below show estimates of sources of health insurance for non-elderly adults (older than 18 and younger than 65 years of age) and children (18 or under) taken only from surveys that provide recent numbers. The estimates generated by the WSPS and the CPS are for the year 2000, while the estimates from the SIPP and the NSAF are for 1999, the most recent year for which data were available.

Source of Health Insurance for All Non-Elderly Adults in Washington State

	WSPS 2000		CPS 2000		SIPP 1999		NSAF 1999	
	%	Std Err	%	Std Err	%	Std Err	%	Std Err
Employment	71.4	0.8	70.2	1.8	74.8	2.0	72.6	1.1
Medicaid/Basic Health Plan	11.5	0.6	7.0	0.9	7.1	0.8	6.7	0.5
Direct Purchase and Other	6.9	0.4	3.8	0.7	6.1	1.0	7.8	0.6
Uninsured	10.2	0.5	19.0	1.5	12.0	1.5	12.9	0.8
No. of cases	10741		1047		906		Not available	

Source of Health Insurance for Children Aged 18 and Younger

	WSPS 2000		CPS 2000		SIPP 1999	
	%	Std Err	%	Std Err	%	Std Err
Employment	68.9	1.3	66.0	3.5	67.6	3.7
Medicaid/Basic Health Plan	18.8	1.0	15.3	2.6	20.6	3.2
Direct Purchase and Other	5.2	0.6	4.9	1.5	4.1	1.3
Uninsured	7.1	0.7	13.8	2.5	7.8	2.0
No. of cases	5343		458		446	

PRECISION OF SURVEY ESTIMATES:

Sampling Considerations: The precision of estimates stems from the design and size of a survey sample. Appendix III, Section 8 includes a basic description of sampling design and size for each of

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

the population surveys in this analysis. Each survey relies on one of two sampling strategies, area probability sampling (APS) or random digit dialing (RDD).

The large-scale, federally sponsored surveys (CPS, MEPS, and NHIS) rely on APS. In these surveys, interviews are generally conducted in the respondents' homes, and efficiency therefore demands that the respondents be clustered geographically. Often APS sampling takes place in stages, where large areas are selected first, then smaller areas or dwelling units, and finally individual family units or households are selected, with each stage using a systematic randomization process. This method has many advantages; it assures excellent population coverage, as it does not depend on the quality of existing lists or the presence of a telephone, and in-person interviewing generally yields very high response rates and high-quality responses. However, members of the sample within a cluster are generally more similar to one another than would be the case in non-clustered samples. While bias from such clustering can be eliminated through standard survey weighting strategies, clustering reduces survey precision for a given sample size. Moreover, sampling strategies in national surveys are generally designed to represent large areas (e.g., regions of the nation) and not individual states. Thus, even though these surveys may have large samples in a given state, the design is not optimized to represent states per se, potentially leading to bias in state-level estimates.

Random digit dialing is the sampling methodology of choice for most of the other population health surveys reviewed. Under RDD, telephone numbers are selected through systematic random sampling. This generates a geographically dispersed sample, which maximizes precision for a given sample size. However, some households do not have telephones, and response rates are generally lower when respondents are approached by telephone.

Some surveys, such as the FHIS, supplement RDD with samples drawn from lists, such as Medicaid or Basic Health enrollment files. This is an efficient way of over-sampling comparatively rare sub-populations. To over-sample sub-populations for which lists are not available, brief screener interviews are generally conducted and eligible households are selected for full interviewing. For a given sample size, over-sampling can reduce precision somewhat, but it enhances analysts' ability to study rare subgroups. Over-sampling of high-variability groups relative to low-variability groups can also increase precision.

Finally, whether APS or RDD, sample stratification is often used to ensure broad representation across geographic regions or other strata. As long as members of each stratum have the same probability of selection (i.e., there is no over-sampling), stratification does not reduce precision even as it assures that a sample is representative.

These sampling considerations have significant implications for analysis of population data for Washington. Although the national surveys have larger sample sizes overall, the WSPS has the largest Washington-specific sample, with approximately 7,000 respondents. WSPS also uses geographic stratification to assure representation of regions of the state. The CPS, on the other hand, has more than 50,000 households included annually, but it has fewer than 1,000 Washington respondents, and because CPS uses an area-probability sample, these respondents are concentrated in two counties (Office of Financial Management Forecasting Division, 2001).

Sub-state Estimates. Policymakers want to know not only the number and characteristics of uninsured in Washington as a whole, but also how coverage is distributed across the state. Sub-state estimates can, for instance, help policymakers target areas that may need more intervention to reduce uninsurance or to expand resources for safety net providers who serve the uninsured. The same

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

features of survey design that determine precision also determine the degree and type of sub-state estimates that a survey can produce.

The following table describes the geographic areas for which estimates can be generated among the population surveys analyzed in this paper. In general, the smaller the geographic unit available, the more informative a picture of how uninsurance varies throughout the state can be drawn. Because many of these surveys are national in scope, not all can address the distribution of the uninsured across the state of Washington. The BRFSS, CPS, FHIS, NSAF, and WSPS all support state-level estimates. The BRFSS and WSPS are the only surveys from which sub-state estimates can be made for the entire states. It is likely that the FHIS and NSAF can also support such estimates, but special arrangements would have to be made with the sponsors of these surveys. Other surveys, namely the CPS and CTS, can make sub-state estimates but these are not exhaustive of all areas, and, in the case of CPS, may have quite limited precision.

Population Survey Support of Local Area Estimates

Survey	Geographic Areas			
	National	**Groups of States**	**Washington State**	**Sub-State Geographic Areas**
WSPS	No	No	Yes	King, Clark, and Spokane Counties, and eight regions.
CPS	Yes	U.S. Census Divisions and Regions	Yes[1]	Large Metropolitan Statistical Areas (MSAs), counties and cities[2]
BRFSS	Yes	Yes	Yes	Regions
CTS	Yes	No	No	Seattle and 11 non-WA MSAs
FHIS	No	10 States	Yes	Multi-county areas by special arrangement[3]
MEPS-HC	Yes	U.S. Census Divisions and Regions	No	No
NHIS	Yes	U.S. Census Divisions and Regions	May be possible by special arrangement	No
NSAF	Yes	13 States	No	Multi-county areas by special arrangement[3]
SIPP	Yes	U.S. Census Divisions and Regions	Limited estimation possible[2]	No

[1] The Census Bureau recommends that state estimates be used with caution, as standard errors may be large. The Census Bureau published state estimates on a three-year average from the March CPS to create more stable estimates for making state-to-state comparisons.

[2] Estimates for these areas are possible, but may be unreliable due to large standard errors and sample design considerations. Estimates of common outcomes such as the proportion of persons with employer health insurance are more likely to be reliable than estimates of rare events (such as persons losing coverage after loss of a job).

[3] In principle, the sampling designs and sample sizes of these surveys permit estimation for multi-county sub-state areas. Sub-state identifiers are not available on public use data sets, but these might be available through special arrangement with survey sponsors.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

SURVEY BIAS:

Sample Frames and Population Under-Coverage. Survey sampling starts with a sampling frame. For RDD, the frame consists of all telephone numbers; for multi-stage APS, the frame consists of all areas, dwelling units within areas, and families within the dwelling units. List samples provide another form of sampling frame. In each case, some members of the target population are missed. In RDD samples, families without phones are missed; in standard APS, homeless persons can be missed; and list samples can include errors or out-of-date information (Lewis et al., 1998). According to the Census Bureau, sample frame under-coverage for the CPS and SIPP is approximately 7 percent, and this varies with sex, age, and race (Bennefield, 1995, as cited in Lewis, et al., 1998). Depending on who is missed, this could either inflate or deflate the estimates of the uninsured or other parameters of interest.

The CPS sample is designed to represent the nation and multi-state regions, and not individual states. Since only a few primary sampling units (PSUs) are selected for the CPS in any given state, frame under-coverage is likely to be a significantly larger problem at the state than the regional or national level. The Census Bureau recommends pooling data for several years to increase the robustness of state-level estimates, but since the number and location of PSUs changes little from year-to-year, pooling is not likely to reduce frame under-coverage bias at the state level. Sample frame under-coverage is a problem that applies to all of the surveys, although few survey sponsors provide estimates of the extent of under-coverage.

Since state-specific health coverage and access surveys are predominantly administered by telephone, it is especially important to understand the potential bias of this method. The percentage of households without telephones has decreased dramatically in the Unites States in the past 25 years, from nearly 20 percent of all households in 1963 to 6.2 percent in 1994 (Keeter, 1995). However, for low-income households, the percentage without telephones is substantially higher (e.g., 17 percent on the 1994 National Health Interview Survey), and the same is true of other major population sub-groups (e.g., on the 1994 NHIS, 10 percent of Black and Hispanic households were without telephones; Anderson, Nelson, & Wilson, 1998). Households without telephones are also less educated, are more likely to be one-person households or very large households, have lived at their current residence for shorter periods (Keeter, 1995), and are more likely to be younger, live in rural-non-farm areas, and be single, divorced, or separated (Freeman, Kiecolt, Nicholls, & Shanks, 1982). Since insurance coverage, health status, health-related behavior, knowledge, and attitudes may differ for these sub-groups, it is important to take steps to reduce this type of coverage bias.

- Three different methods have been suggested as ways to correct for non-telephone coverage bias. The first method is that employed by large national surveys such as the CTS, the FHIS, and the NSAF, where both a telephone sample and an in-person non-telephone sample are included. Although this is the most effective way to reduce telephone coverage bias, it is quite costly and many state and local surveys may not have adequate funding for large in-person samples. For example, in the 1997 NSAF, even when sampling from neighborhoods identified by the Census as low telephone service areas, approximately 22 households were contacted for every one non-telephone household located (Judkins, Shapiro, Brick, Flores-Cervantes, Ferraro, Strickler, & Waksberg, 1999). In-person surveys are at least twice as costly as telephone surveys (Groves, 1989), and there is some evidence that the difference is even greater (McAuliffe, Geller, et al., 1998).

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

- The second method for reducing non-telephone coverage bias is to use existing data from large surveys that include non-telephone respondents to develop a weighting scheme (see, for example, Anderson, Nelson, & Wilson, 1998; Freeman, Kiecolt, Nicholls, & Shanks, 1982). Weights comparing the telephone data to the non-telephone data on key demographic variables and other variables of interest (e.g., health insurance coverage, health status) can be derived from these surveys and applied to independent survey data.
- The third method for reducing non-telephone coverage bias is to include a question(s) on the survey that assesses transient telephone coverage (e.g., "At any time during the past twelve months has your household not had a telephone?"). The data from the transient telephone sub-group, which comprises about half of the total non-telephone population (Keeter, 1995), could be used to supplement the standard weighting procedure or to directly derive non-telephone estimates for variables of interest. It has been demonstrated that households with transient telephone coverage are much more similar to continuous non-telephone households than to continuous telephone households on both demographic variables and other variables such as health status and health insurance coverage (Keeter, 1995). This technique has been recently recommended as a cost-effective way to reduce the bias from telephone non-coverage (McAuliffe, Geller, et al., 1998).

A number of surveys reviewed here utilize both telephone and in-person interviewing. For example, the CTS, the FHIS, and the NSAF all include field samples of households without telephones, but rely primarily on telephone interviews for the vast majority of respondents. The two panel surveys reviewed here (MEPS-HC and the SIPP) use a combination of in-person and telephone interviewing across the different waves of data collection, allowing for the convenience of telephone interviewing while maintaining the rigor of in-person interviews. The remainder of the surveys utilize face-to-face interviewing exclusively, with the exception of the WSPS. The WSPS is a telephone-only survey that does not include any in-person interview sample. Although post-stratification weighting adjustments were made to correct for this, the WSPS is the most likely survey reviewed here to suffer from under-coverage of the non-telephone population.

Response rates. The survey response rate is a commonly reported survey statistic, and non-response can be a significant source of bias in survey estimates. Surveys measure response rates in different ways, making cross-survey comparisons difficult (Atrostic, Bates, Burt, Silberstein, & Winters, 1999), but comparisons are an important way to judge the potential for bias. Although methods to maximize response rates will vary by the nature of specific surveys, response rates are a reflection of the following:

- The salience of a survey's topic (e.g., health survey response rates were generally higher during the Clinton health reform debate)
- A survey's sponsorship (government-sponsored surveys generally have higher response rates than private surveys)
- Survey mode (in-person surveys generally attain higher response rates, followed by telephone and mail response rates)
- Whether interviews are conducted at a single point in time or repeated multiple times (the latter leading to lower total response)
- Follow-up methods (more is generally better)

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

There is no established standard of an adequate response rate, but most population surveys of the type considered here report response rates between about 60 percent and 90 percent (see Table 6). Although higher response rates are better, techniques exist to minimize bias from sub-optimal response rates (Cox and Cohen, 1985). Specifically, statistical strategies can be used to up-weight respondents who are similar (e.g., demographically or geographically) to non-respondents. These techniques can assure that basic demographic distributions are equivalent to Census or other "gold standard" estimates. The large federal surveys in our analysis report the higher response rates (e.g., over 90 percent for the CPS and NHIS). Because of the pervasiveness of telemarketing and the proliferation of telephone lines not used for voice communication (e.g., modem lines), calculating response rates for RDD samples and achieving high rates in such studies has become increasingly difficult. The response rate reported by the WSPS is lower than the other surveys in our analysis: 59 percent for the general sample in 1998 and 43 percent for the same sample in 2000. The rates for the expanded sample are even lower: 43 percent in 1998 and 29 percent in 2000. Non-response to individual survey items can also lead to bias. Again, techniques are available for minimizing such biases.

Respondent selection. Allowing respondents to answer questions regarding someone other than him or herself (i.e., proxy responses) poses the problem that the respondent may not be able to answer questions accurately. For example, one adult may not know the true health insurance status of another adult in the family, although they may believe that they do and subsequently respond incorrectly. However, relying on exclusive self-response can exacerbate under-coverage of the population, as it is harder to access and interview each household member, thus reducing the number of people for whom data is collected.

Among those surveys that do permit proxy response, the majority request to speak with the "most knowledgeable adult" (MKA). Speaking with the MKA should improve accuracy, although there is the possibility that even the most knowledgeable person does not know everything about all household members and introduces some error into the data. An example of a survey that does not have the MKA as the respondent is the BRFSS, which does not permit proxy response. For the BRFSS, the respondent is simply a randomly selected adult who is asked to report on him/herself exclusively. Large federal surveys, such as the MEPS, supplement MKA interviews with self-administered questionnaires for selected questions (e.g., health-related behaviors and health status). Although this technique can reduce proxy respondent bias, it is effectively a survey-within-a-survey and can add significant costs.

Interview mode. Fowler (1993) describes many of the pros and cons of conducting interviews in person versus over the telephone. In-person interviewing can encourage people to take the survey more seriously and to consider their responses more carefully, resulting in greater accuracy. Visual aids used for in-person interviewing can help respondents follow complex instructions or sequences more easily, and it may be easier for the respondent to maintain their concentration and stay focused on the interview. In addition, in-person interviews can increase the number of people willing to respond. The primary benefits of telephone interviewing are financial, as they are significantly less expensive to conduct than in-person interviews. Although telephone surveys may be better for reaching certain sub-groups of respondents, particularly those in urban areas (Fowler, 1993), the main drawback of telephone surveys is that households without telephones will not be included in the sample.

Recall bias. Respondents may incorrectly reply to survey questions for a variety of reasons, but perhaps the most common reason is that they do not correctly remember the correct response.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Incorrect reporting for this reason is considered recall bias. Recent events are more easily remembered than more distant ones (Groves, 1989). The CPS asks people to report their health insurance status for the previous year, rather than their current insurance status (like the WSPS) or their status for a shorter period of time (e.g., the SIPP asks about the preceding four months). Event memory decreases significantly over a one-year period, particularly for non-salient events, a category in which health insurance status falls for many people. Because of its long reference period, the CPS is particularly vulnerable to recall bias. It is easy to imagine a respondent not recalling a brief spell of uninsurance that occurred very early in the previous year, and subsequently being incorrectly classified by the CPS. In addition to leading to recall bias, the CPS's question wording increases the likelihood of misinterpretation of the item, an issue that is discussed further later in the report.

Variation in reporting enrollment in state-sponsored coverage: Reporting of enrollment in state-sponsored coverage appears to be of particular concern, and the way surveys deal with this problem can lead to variations in estimates. Lewis and colleagues (1998) review a number of reasons why state-sponsored coverage may be under-reported:

- Stigma is associated with public assistance programs, thus discouraging people from reporting it.
- Respondents may not realize they are enrolled in Medicaid at a given point in time.
- Individuals enrolled in Medicaid managed care plans may incorrectly identify themselves as being enrolled in private managed care, further reducing the number of people identifying as being in Medicaid.
- State Medicaid programs often go under different names, such as Hoosier HealthWise and Husky Health Plan. Respondents may not think of their health plan as being a Medicaid plan if it has a different name, and only some surveys include state-specific program names in their questionnaires.
- Failing to ask about specific programs by name in addition to Medicaid likely leads to under-reporting of enrollment in those programs. The WSPS has survey items covering all the state's public health insurance programs. Although the CPS has a long list of state-specific programs, Washington's Basic Health was not included in 2000, increasing the likelihood of reporting errors.

Medicaid under-reporting can be corrected, to some extent, through statistical imputation methods. Imputation is the process by which respondent reports of coverage are changed based on other respondent characteristics. For example, even if it is not reported, the CPS uses imputation to assign Medicaid coverage to children under 21 whose families have Medicaid and to people who receive welfare who live in states that require them to have Medicaid coverage (Lewis et al., 1998). In addition, the CPS also imputes insurance status for those who reported that they did not know what coverage they (or a household member) had. The Urban Institute adjusts CPS data for under-reporting of Medicaid in the CPS by using a micro-simulation model to test for Medicaid eligibility among respondents who did not report Medicaid coverage and imputing coverage to some of the eligibles (Nelson & Mills, 2001). This resulted in a decrease in the estimate of uninsured children by 30 percent using the March 1995 CPS. However, this may overcompensate for the CPS's overly conservative estimate. Thus, the issue of imputation has implications not only for the estimates of

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

the specific types of insurance Washingtonians have, but also estimates of whether they have health insurance at all.

Fluctuation of estimates (CPS) from survey to survey: The CPS is thought to over-estimate uninsurance compared to state population surveys (State Health Access Data Assistance Center, 2001a; State Health Access Data Assistance Center, 2001b). Preliminary analyses of Washington uninsurance rates demonstrate the same pattern when the WSPS is compared to the CPS and the SIPP. For 2000, the CPS estimate of the number of uninsured in Washington is almost twice that of the WSPS. The SIPP, which is similar to the CPS in terms of its sampling strategies, produces an estimate of the uninsured in Washington that is much more aligned with the WSPS than the CPS. Figures 2 and 3 (figure 1 not included) illustrate that the discrepancies among the surveys are not unique to 1999/2000 data. Similar patterns can be found over time: the CPS tends to be discrepant from the other surveys, particularly in its estimates of uninsured children. In addition, the CPS shows more variability than the other surveys, as its estimates fluctuate from year to year more than those of the other surveys do. Again, this is most true among its estimates of uninsured children. The variability in the CPS over time and the historical lack of concordance with the other surveys are reasons to be cautious of the CPS estimates of the uninsured at the state level.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Figure 2. Uninsured Non-Elderly Adults, Age 19 to 64, Washington State, 1993-2000

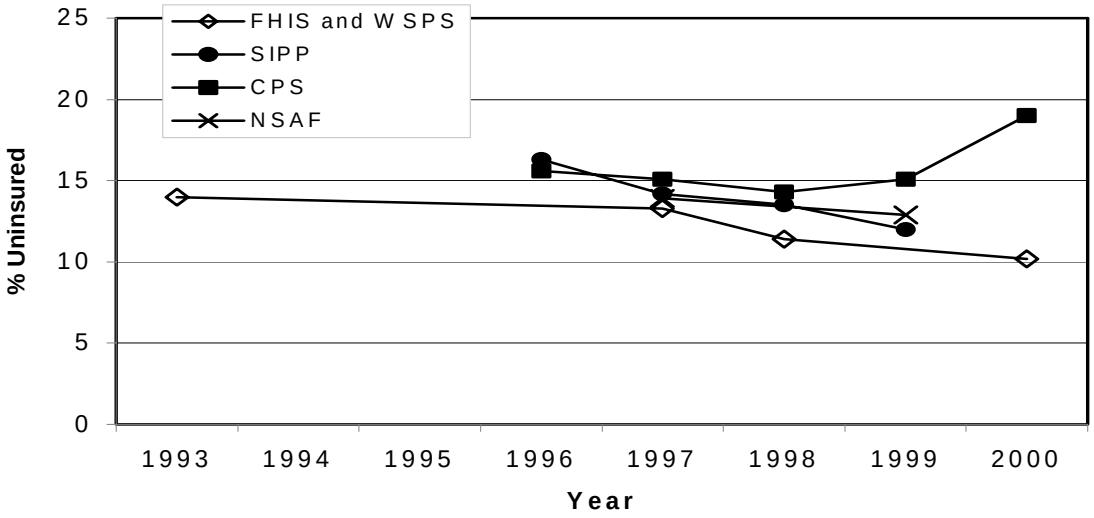
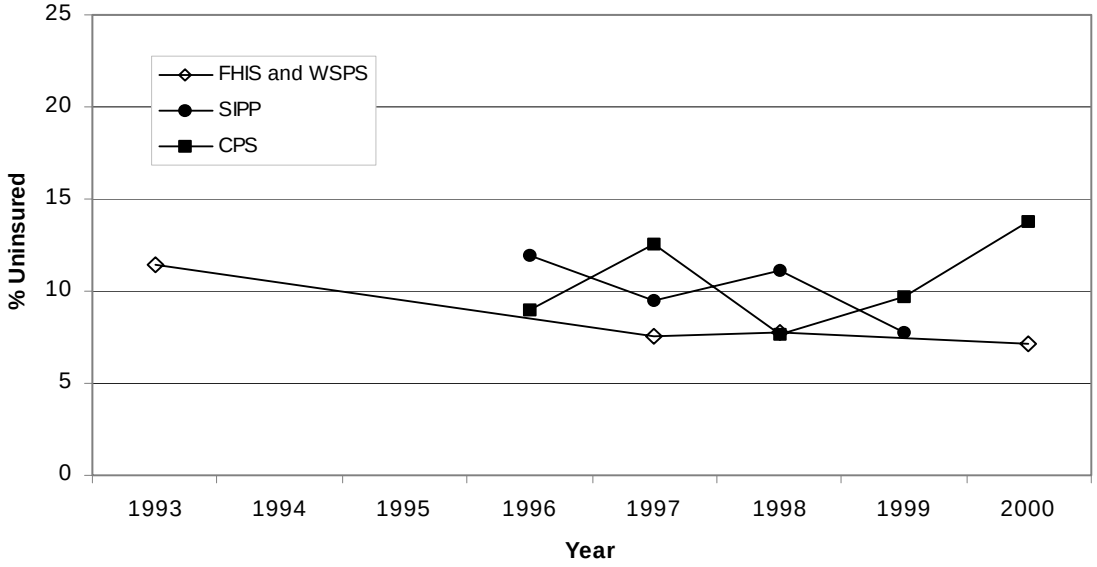


Figure 3. Uninsured Children, Age 0-18, Washington State, 1993-2000



* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Verification questions. Verification questions check that a person who has responded that they are not covered by any form of insurance mentioned in the interview is in fact uninsured. Verification questions are also asked for other members of a household when proxy response is permitted. This question is generally asked after the respondent has stated that he or she is not covered by any of the forms of coverage mentioned. A typical verification question is "I have recorded that you were not covered by a health plan at any time in 1999. Is that correct?" (CPS, 2000). Because the question is designed to catch people who would otherwise be counted as uninsured, the anticipated effect of including this question is a lower uninsurance estimate. Verification questions may, in fact, correctly identify persons who are covered but were reported as uninsured, but these questions may also pressure some respondents to give a socially desirable response that a person is covered, even if he or she is not.

The CPS did not have a verification question and has historically generated higher estimates of uninsurance compared to other national surveys. In March 2000, a verification question was included in the CPS in order to test its effects on uninsurance estimates. As expected, including this question resulted in a significant decrease in the number of uninsured estimated by the CPS. At a the national level, eight percent of those who would otherwise have been classified as uninsured reported that they did in fact have health insurance coverage. This lowered the CPS estimate of the uninsured by 3.3 million people (Nelson & Mills, 2001).
Similarly, the CTS recently added a verification question, and it resulted in a decrease of approximately 7 percent in the number of uninsured, reducing the estimate from 35.1 million to 32.8 million nationally (Nelson et al., 2001).

The surveys reviewed vary on whether or not they include a verification question. Neither WSPS 2000 nor the SIPP have a verification question, and they subsequently calculate the uninsured as a residual. The MEPS-HC, the NHIS, and the NSAF do have verification questions (Office of the Assistant Secretary of Planning and Evaluation, 2001) and WSPS has included a verification question in the 2002 survey. Even with the verification question, the CPS's estimate is significantly higher than those of the WSPS or the SIPP.

Reference periods. The wording of insurance questions can also make a significant difference in the estimates of uninsurance that can generated by each survey.

	WSPS	CPS	BRFSS	CTS	FHIS	MEPS	NHIS	NSAF	SIPP
Uninsured point in time	X	X[1]	X	X	X	X	X	X	X
Uninsured entire year			X	X	X	X	X	X	X
Ever uninsured prior year		X	X	X	X	X	X	X	X
How long uninsured			X	X	X	X	X	X	X
How long covered			X						X

[1] The CPS has experimented with adding questions about current coverage, but the questions measuring coverage in the prior year remain the primary coverage concept in this survey.

Point-in-time uninsured estimates can be derived from all of the surveys. However, until 2000, the CPS only supported annual (prior year) uninsured estimates. In the main battery of CPS questions, respondents are asked whether members of their household had any of each source of coverage at

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

any time in the previous year, and those who respond that they have no coverage should be interpreted as reporting that they were uninsured for the entire year. The validity of this method is controversial. Many analysts believe that many respondents report current insurance status rather than status during the preceding year, which could in part account for the CPS's higher estimates of uninsurance (Lewis et al., 1998). The WSPS asks only about coverage at a point in time. The remaining surveys support both current and historical uninsured estimates.

Cognitive factors. A number of cognitive factors can affect the respondents' accuracy on the insurance questions.

- The length of recall periods used by those surveys that are not asking about current status can affect accuracy. Cognitive testing of surveys indicate that accuracy significantly declines with longer reference periods (Groves, 1989). The CPS asks respondents to recall insurance status for the previous year, and the SIPP asks for the previous four months. The MEPS-HC's reference point changes depending on when the respondent was interviewed (January 1 of that year is a constant reference point). The lack of accuracy related to longer recall periods are one important reason that point-in-time estimates may be preferable to others.
- The level of detail included in the questionnaires can affect the accuracy of responses. For example, the SIPP asks extremely detailed health insurance questions, such as asking to see respondents' Medicaid and Medicare cards. In addition to improving accuracy by objectively checking respondents' answers, this may prime other health relevant information, resulting in improved accuracy on other items that are not directly related to Medicaid or Medicare, such as utilization. Neither the WSPS nor the CPS includes particularly detailed health insurance questions, nor do they seek objective verification of interviewees' responses.
- In much the same way that the level of detail of the questions can affect accuracy, so can the focus of the survey. A focus on health may prime health insurance relevant information and result in greater accuracy of responses. Neither the CPS nor the WSPS focus specifically on health, and the health insurance questions are toward the end of the surveys, which may decrease attention and resultant accuracy.

Non-response to insurance questions. Although item non-response can be an important source of bias for many measures, it is particularly important for coverage estimates. There are multiple ways of dealing with people who do not respond to any of the health insurance questions. The most common method among the surveys reviewed was to consider these respondents uninsured, as occurred with the WSPS, the MEPS-HC, the CTS, and the NHIS. However, this is likely to artificially inflate estimates of uninsurance.

Definition of uninsurance. Although many of the issues noted have unpredictable effects on uninsurance estimates, the way that uninsurance is defined usually has predictable effects on uninsurance estimates (Lewis et al., 1998). For example, the CTS counts people who report using the Indian Health Service as having health insurance, while none of the other surveys do (Office of the Assistant Secretary of Planning and Evaluation, 2001). Similarly, the MEPS-HC groups all public insurance together, something the other surveys do not do. This variability renders cross-survey comparisons extremely difficult. Fortunately, both the WSPS and the CPS provide public use data sets that allow researchers to modify some of the definitions and render the surveys more

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

comparable. Variability in the way age, income, ethnicity, and insurance types are measured are potentially important differences across surveys, but are usually easily corrected.

Some differences in the way the data are reported cannot be corrected (e.g., state health insurance programs and Medicaid are reported together for the CPS because they did not ask about Washington's Basic Health separately in 2000). However, it is possible to adjust for some differences post-hoc, by standardizing the groups for which the estimates are made. For example, it is possible to standardize the definition of non-elderly adult; (for Washington's grant analysis work the definition is over 18 and under 65 years of age). More importantly, it is possible to standardize the categorization of insurance types wherever allowable. (For Washington's grant analysis work a hierarchy was used to generate estimates, so that if a respondent reported that he or she was receiving both Medicaid and employment-sponsored insurance, the respondent was counted as having only employer-sponsored insurance. The hierarchy reflects how coverage works in practice, with public sources paying only after other coverage is exhausted.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Washington State Planning Grant on Access to Health Insurance

Methodology for Developing Key Data Constructs Not in WSPS

(Excerpted from draft Consultant Report on Profiles of Washington's Uninsured) *

The profile of the uninsured and the analyses of coverage gaps and barriers to coverage are based primarily on data collected in the 2000 Washington State Population Survey (hereafter 2000 WSPS). The purpose of this appendix is to describe methods used to develop key constructs for our analysis that are not directly measured in the survey.

Matching to Other Surveys

We used three other surveys to impute important characteristics for our analyses that were not measured in the 2000 WSPS. These other surveys include: the 1998 Washington State Population Survey (for a measure of any period of uninsurance during the year); the 1997 RWJF Washington Family Health Insurance Survey (for a measure of the length of the uninsurance spell in progress); and the 1997 RWJF Employer Health Insurance Survey (for detailed information about the offer of employer health insurance). The imputation involves matching observations in the 2000 WSPS and the host survey based on characteristics common to both.

The longitudinal insurance measures were imputed using a probit regression model that was estimated from the host data set to explain the characteristic in question (having any period of uninsurance during the year or having a spell in progress of 1 year or more). Explanatory variables in these regressions included: age, health status, poverty level, race/ethnicity, education, availability of employer-offered insurance, whether the primary earner was self-employed, and number of earners in the family. For each observation in the 2000 WSPS, we predicted the value of the characteristic as:

$$y = 1 \text{ if } f(Xb + m) > 0.5 \text{ , and } y = 0 \text{ otherwise.}$$

The y values we impute take on the value 1 if the person was uninsured at any time in the last year and 1 if the current uninsurance spell has been in progress for a year or more. The X are the explanatory characteristics defined above, the b are the coefficients from the probit model, the m is drawn from a normal distribution with mean equal to 0 and variance equal to 1, and f is the standard cumulative normal distribution. This imputation is analogous to reweighting the host data to match the distribution of explanatory characteristics in the 2000 WSPS survey.

Because we wanted to study a number of characteristics about employer-sponsored insurance, we synthetically matched each worker in the 2000 WSPS to an employer in the 1997 RWJF Employer Health Insurance Survey. That is, rather than imputing characteristics of employer-sponsored insurance one by one, we attached all of the characteristics of a single employer to each worker. This process preserves the joint distribution of these characteristics. We assigned workers to employers based on industry, size of the business, the wage mix of the workforce and the business and the worker's wage, and information about whether the household survey respondent worked for an employer that offers insurance. Employers and workers were assigned to one of 20 industry/size groups. The industry groups were agriculture/forestry/fishing; construction/mining/manufacturing; trade; communications/transportation/utilities/ and finance/insurance/real estate; professional services; other services; local government; state government; and federal government. All industries except agriculture/forestry/fishing and the government groups were categorized by number of

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

workers in the business: fewer than 10, 10-25, 26-50, and 51 or more. Each of these industry size groups was classified by the wages of the workers in the business: low-wage businesses—those with 2/3 or more workers earning less than $10 per hour –and other businesses. A low-wage worker in the 2000 WSPS (i.e. one earning less than $10 per hour) was probabilistically assigned to an industry/size/type of business on the basis of the reported industry and size of his/her employer and the proportion of low-wage workers in this industry size group that are employed by low-wage businesses. For example, if 80 percent of all low-wage workers in the other service industry who work for business with fewer than 10 workers are in a low-wage business of this type, then the worker is assigned to a small, other service, low-wage business with probability of .8 and to a small, other service, higher-wage business with probability .2. Within the assigned type of businesses, random selections were made.

For some workers, we have information about whether the employer offers insurance, and we used this to create a subset of the sample including businesses to which a match might be made. For example, if there is a single worker in the family, we know that coverage is available if the worker has employer coverage or reports that it is available. In such case, we would assign the worker only to businesses that offer employer-sponsored insurance (and we recalculate the probability of working for a low-wage or high-wage business to account for this subset). If there are two-workers in the family, and the workers are covered by employer coverage or report that employer coverage is available, we know that at least one of the workers is employed by a business that offers coverage. We assume that a full-time worker at the largest of the businesses is offered coverage in this case and assign that worker to a business that offers employer-sponsored coverage. The other worker in the family can be assigned to a business that offers coverage or to one that does not. If the worker or workers in the family are full time workers and report that coverage is not available, we assume that the employer does not offer coverage and limit our assignment to these businesses. However, if the worker who does not have coverage available is a part-time worker, the worker can be assigned to an employer that offers coverage or one that does not.

The analysis of workers and their assigned employers can thought of as reweighting the 1997 RWJF Employer Health Insurance Survey using employee weights derived from the 2000 WSPS survey. The distribution of workers according to characteristics of the business to which they linked is shown in Table 1. We compared the distribution of employees by industry, low-wage vs. other business, size of business, and whether insurance is offered by the business using these new weights and the employee weights from the 1997 RWJF Employer Health Insurance Survey. The results were not markedly different.

Eligibility for Public Programs

To analyze access to insurance for the uninsured, we identified uninsured persons who are eligible for public programs based on information in the 2000 WSPS. This coding represents an approximation and an abstraction from the complexity of eligibility rules; our coding is constrained by measures available in the survey. The rules we used for determining eligibility are as follows:

For children age 18 or younger:

Medicaid: The child is eligible if he/she is a citizen or non-citizen resident in the U.S. 5 years or more, and adjusted family income is less than or equal to 200 percent of the federal poverty level. Adjusted family income is total family income less $90 per month per worker in the family less the costs of paid child care per month related to working expenses less child support payments (as

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

reported in the survey). We approximate allowed deductions for child care costs by determining from the survey (1) whether the family reports making child care cost payments and (2) if there is a working adult. If yes, we deduct an amount of childcare costs based on the age and county-specific child care cost standards from the Pearce Self-Sufficiency Standard (Pearce & Brooks, 2001).

Children's Health Program: The child is eligible if a non-citizen and resident less than five years and adjusted family income is less than or equal to 100 percent of the federal poverty level. Adjusted income is determined as described for Medicaid.

CHIP: The child is eligible if he/she is a citizen or non-citizen resident in the U.S. 5 years of more and adjusted family income is less than or equal to 250 percent of poverty. Although CHIP is not an entitlement, our estimates are that current program funding would be sufficient to cover all uninsured children not otherwise eligible for a public program. Thus, our estimates of eligibility do not take into account capacity limits.

For adults:

Medicaid: The adult is eligible if there are children in the family and the adult is related to the child, the person is a citizen or non-citizen who has been a resident of the U.S. for 5 years or more, and adjusted family income is less than or equal to 45 percent of the federal poverty level. Adjusted family income is total family income less 50 percent of earned income less the costs of paid childcare per month related to working expenses less child support payments.

State Family Assistance program: The adult is eligible if there are children in the family and the adult is related to the child, the person is a non-citizen who has been a resident of the U.S. for fewer than 5 years, and adjusted family income is less than or equal to 45 percent of the federal poverty level. Adjusted family income is as described for Medicaid adults.

SSI related programs/GAU: The person is eligible if disabled, a citizen or non-citizen who has been a resident of the U.S. for 5 years or more, has own *earned* monthly income of less than $740 per month and own *unearned* monthly income of less than $591 per month in area 1 or $570 per month in area 2. The incomes are as measured in the survey. We have operationalized disabled as reporting having a long lasting condition such as blindness, deafness, or severe vision or hearing impairment or reporting having a condition that prevents the individual from working for pay.

Medicaid buy-in: The person is eligible if disabled, a citizen or non-citizen who has been a resident of the U.S. for 5 years or, is working, has family income of less than 450 percent of poverty , and previously received SSI payments. Disability is operationalized as described above. As a proxy for previously receiving SSI payments we use the indicator that the individual received TANF, GA, or SSI in 1999.

For adults and children:

Basic Health program (BH): Because the BH program is currently enrolled at capacity, we assume that uninsured individuals do not have current access to the program. However, we consider two alternative scenarios: full funding of BH, and planned funding through the next biennium. Under full funding of BH, all adults and children are eligible if family income adjusted for childcare costs (as described earlier) is less than or equal to 200 percent of poverty. Under planned funding through the next biennium, an additional 50,000 persons could be accommodated in the program. We probabilistically designate uninsured adults and children who are not otherwise eligible for a public program to allow an additional 50,000 enrollments in the BH program to represent this scenario.

---

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Estimating Adjusted Relationships

In many of our analyses we show the simple bivariate relationship between an outcome (such as having insurance) and a characteristics of the individual (such as age) and an adjusted relationship. The simple bivariate relationship shows the effect of the variable under study and all variables associated with it. For example, if older individuals are in poorer health and have lower income than younger persons, then the bivariate relationship between having insurance and age would also reflect the effect of income on having insurance and the effect of health on having insurance. The adjusted relationship controls for all of the other variables to show the marginal effect of the characteristic under study, in this example, age. To do this, we fit dichotomous models (using logistic or probit regression) to explain the outcome of interest (for example having insurance), as a function of all characteristics that we think are associated with it. To measure the adjusted effect of a variable, say age, we use our fitted relationship to predict the outcome for everyone in the population as if they were all young, and we average these predictions to obtain an adjusted measure for the young. This shows what we expect the outcome would be if all of the young had the same distribution of other characteristics (say income and health) as the population as a whole. We then predict the outcome for everyone in the population as if they were all old, and average these predictions for the adjusted measure for the older population. Again, this shows the expected outcome for older persons if they all had the same distribution of characteristics of the population as a whole, and so the same distribution of characteristics in our population for the adjusted measure for the young. The comparison of these two predicted average outcomes then shows the difference in the outcome for the young and old after controlling for all other factors.

Index of Access to Affordable Coverage

We developed an index of affordability for each sample person and family in the survey. The goal of this effort was to assess how many uninsured families have access to affordable coverage and the characteristics of the uninsured that do and do not have such access. Thus, this differs somewhat from the purpose of the affordability analysis which measures the income needed for a typical family to afford various types of coverage in the state. Our procedures and assumptions in general, however, follow those described in the affordability analysis (Please see the attached Affordability Appendix). We modified some of the affordability analysis methods to incorporate specific information we had about each individual and family from the survey that cannot be accounted for in looking at an average or typical family.

We linked the Pearce self-sufficiency standard (Pearce & Brooks, 2001) to each family in the survey based on the family composition and the county of residence. The Pearce standard is developed for 70 distinct family types based on the age and number of adults, and the age and number of children in the family. The 70 types consider all possible family configurations with up to 3 children. For families with more than 3 children, we calculated the marginal cost per child in each of the four age groups considered in the Pearce model (infant, preschooler, school age, teenage) based on the difference in cost for a 2 adult family with 2 children in the age group and a 2 adult family with 1 child in the age group. This marginal cost per child of a given age was then used to increment the standard to account for families with more than 3 children. We use the Pearce model to measure the family needs for all non-health related expenses. Because the survey was taken in 2000, we adjusted the Pearce standard from 2001 to 2000 dollars using the consumer price index.

---

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Premium costs for the best option available to the individual or family were then calculated as follows:

For those eligible for Medicaid, CHIP, GAU of SSI-related programs, Children's Health Program, and State Family Assistance programs, the individual cost for insurance is set to zero.

For all other individuals, we establish a premium for the family based on the best option for each family member. For those eligible for BH, premiums are based on the sliding income scale for the lowest premium plan, to correspond to the assumptions of the affordability analysis. For those who have access to an employer health plan, we used the employee's share of the cost for self-only coverage or family coverage as appropriate using the required contributions from the 1997 RWJF Employer Health Insurance survey employer to which the workers in the family were linked (as described earlier). These premiums were adjusted to 2000 dollars using the medical component of the consumer price index. We used this specific detail, rather than use the average costs for a small employer as applied in the affordability analysis, because we want to account for differences in premium costs and employer contribution share across business sizes and industry.

For persons who are not eligible for a public insurance program and do not have access to employer-sponsored coverage, we used a premium schedule for the purchase of either individual insurance or WSHIP insurance. The premium schedules vary by the age and number of adults in the family purchasing in this market, and by the size of the family and accord with the premiums for this program assumed in the affordability analysis. Persons reporting that they are in fair or poor health are given a WSHIP premium; others are given the individual market premium. Current tax law permits self-employed persons to deduct up to 50% (in 2000) of the cost of their individual health insurance premiums, even if they do not otherwise itemize deductions. This effectively lowers the price of insurance to .5*Premium+(1-marginal tax rate)*.5 Premium. We used information on marginal tax rates for single person families and other families by level of total family income from the U.S. Statistical Abstract to make this adjustment for the premiums for self-employed persons and their family members.

To accord with the affordability analysis, we assumed three different health statuses and we adopted levels of total spending and out-of-pocket spending that are consistent with the affordability analysis. The healthy in our analysis are those who report health status of excellent: they are assumed to have no medical care costs. Those in average health are those reporting health status to be very good or good. The sick are those who report health to be fair or poor. We assume a total level of annual insured spending for health care services in 2001 dollars for those in average health as follows:

Under age 19: $1471

Age 19-25: $2254

Age 25-34: $2724

Age 35-44: $3165

Over age 44: $5494.

These total spending assumptions accord with the out-of-pocket spending and cost-sharing assumptions for individual coverage in the affordability analysis. We assume the sick have total spending that is three times this level. We adjust the 2001 dollars to 2000 dollars for our affordability index for persons in the 2000 survey.

---

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

To determine out-of-pocket spending for those with access to employer coverage, we use measures of the actuarial value of the plan offered by the employer to which the workers in the family are linked. The actuarial values are measures that were developed for each plan offered by employers in the 1997 RWJF Employer Health Insurance Survey based on detailed information about the plan benefits. Again, we do this in order to take account of differences in benefits offered by large and small employers and across industries. The actuarial value is an estimate of the share of medical spending that would be reimbursed by the plan; the individual's out-of-pocket share is one minus the actuarial value. This latter share is then multiplied by spending to determine out-of-pocket payments for health services. For the person in average health, we use the actuarial value for the average person. For the sick person, we use the actuarial value for persons in the top 25 percent of the expenditure distribution in order to take into account a higher expected actuarial value as spending increases because of the lower weight of deductibles and because of out-of-pocket limits on spending.

For all other plans, we used the same assumptions employed in the affordability analysis.

Our index of affordability is then measured as follows: For individuals eligible for Medicaid, CHIP, GAU of SSI-related programs, Children's Health Program, and State Family Assistance programs who do not have premium payments or out-of-pocket cost-sharing, the affordability index is set to 1. For all other persons, we compare the Pearce monthly requirements for non-health spending for the family plus the monthly family premium payments for the best option available to family members plus the average monthly out-of-pocket payments for all family members to the family's monthly income. If family income is greater than the monthly requirement for non-health spending and health spending, then the index is set to 1; otherwise it is set to zero.

The affordability index is not an index of likelihood of purchase because it does not account for other priorities of the family, risk aversion, or attitudes about health insurance or health care. Nonetheless, it does discriminate quite well between those who do and do not have coverage; among those who purchase insurance, 91.5 percent are measured to have access to affordable coverage. Among the uninsured, only 58.5 percent are measured to have access to affordable coverage (including public insurance).

The index looks at whether family income is sufficient to cover non-health care and health care resource requirements given the best insurance option. However, it does not take into account that individuals are likely to incur medical costs even without insurance, and so their direct payments for medical care may be lower with insurance; they may have more income left to pay for other needs. Therefore, we also looked at a variant of the index in which we measure the cost of insured health care as the premium less any savings in out-of-pocket spending from purchasing insurance. We then compared the Pearce standard for non-health care plus the cost of insured health care to the family income. This index requires a measure of expected payments for medical care if uninsured. To obtain this, we assumed that spending by the uninsured is 75 percent of insured spending; this is based on a large body of literature that looks at differences in use by the insured and uninsured. This literature obtains a wide range of estimates, but 75 percent represents a reasonable mid-range of the estimates. We also assumed that a family would not pay more than 25 percent of its income out-of-pocket for care, even if uninsured; if incurred expenditures exceed this amount the family is assumed to seek charity care. In the aggregate, our conclusions are not very sensitive to the use of this alternative measure. Using the alternative measure, 61.4 percent of the uninsured have affordable coverage, in contrast to the 58.5 percent mentioned above. However, as we would expect, taking into

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

account the savings in out-of-pocket payments in our measure does affect differences in affordability by health status, as reported in the text.

Estimating Supply Premiums for Workers not Offered Insurance

We are interested in looking at whether workers in businesses that do not offer health insurance face higher premiums for group coverage than workers in business that do offer coverage. We do not observe these premiums directly, but we can estimate the supply premium based on data about premiums paid for workers in businesses that do offer coverage and how those premiums vary with characteristics of the business and its workers. We assume that premiums are given by the relationship:

$$\text{Premium} = Z\,g + e.$$

If we know this relationship, we can then impute premiums that would have to be paid for workers in businesses that do not offer insurance.

However, because we only observe premiums for those who offer insurance, if we estimate this relationship on the data available to us, we must take account the potential selection bias; the equation can not typically be consistently estimated using ordinary least squares. But consistent estimates of g can be obtained using the two-stage estimation procedure suggested by Heckman (1979). For the two-stage procedure, we first estimate the selection equation that distinguishes those who do and do not offer insurance as a probit model given by:

$$\Pr(\text{Offer Insurance}) = F(X\,a + Z\,g\,b), .$$

where the X are characteristics that are assumed to directly affect the decision to offer insurance and the Z are characteristics that affect premiums (and some may also be in the X vector). Conditional on offering insurance and observing premiums, the premium equation is:

$$(\text{Premium}|\ \text{Offer Insurance}) = Z\,g - d\,[f(W)/F(W)] + v,$$

where $W = X\,a + Z\,g\,b$, $- d\,[f(W)/F(W)] = E(e|\text{Offer Insurance})$, $d = \text{cov}(e, h)$, and $E(v)=0$. The two-stage estimation procedure involves fitting the reduced selection equation to obtain estimates of W, which are used along with the observed Z to estimate g, and d in the premium equation. To estimate the equations, we assumed the following variables are in the X vector (that is, they directly affect the offer of insurance): industry, firm size, the age mix of workers, whether union employees, the gender composition of workers, the work hours composition of employees, whether a seasonal business, and the amount of turnover in the workforce. Characteristics assumed to affect premiums but not the offer include the number of years in business and whether ever denied coverage.

We then estimate predicted premiums for those not offering insurance as :

$$\text{Premium} \mid \text{Doesn't Offer Insurance} = Z\,g^* + d^*[f(W^*)/\{1-F(W^*)\}] + v,$$

where v is drawn from a normal distribution with mean 0 and variance and is estimated as the residual variance from fitting the premium equation. For a further discussion of this technique for estimating offer premiums see Marquis & Louis (2001).

References

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

1. Heckman, J.J. (1979) Sample selection bias as a specification error, *Econometrica*, Vol. 47 (1). p. 153-161.

2. Marquis, M.S. & T.A. Louis, (2001) On using sample selection methods in estimating the price elasticity of firms' demand for insurance, *Journal of Health Economics*, in press.

3. Pearce, D. B. and Brooks, J. (2001) *The Self-sufficiency Standard for Washington State*, Washington Association of Churches, Seattle WA.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

Washington State Planning Grant on Access to Health Insurance

Background for Potential Future Improvements in WSPS

(Excerpted from draft consultant report on Data for Assessing Access to Health Insurance Coverage in Washington State) *

Dynamics of uninsurance. Measures related to dynamics of coverage, such as the duration of uninsured spells, identification of events leading to loss of coverage, and eligibility for COBRA coverage, are best measured through true longitudinal surveys (i.e., where the same individuals are interviewed repeatedly over time). To limit costs associated with such an approach, our consultants suggest that there may be utility in experimenting with alternative formulations of history questions. For example, respondents could be walked through a simple a set of questions geared to tax respondent memories the least. An example battery of questions would include:

For respondents with coverage:
Q1. Was there any time in the past 12 months, that is since <MONTH/YEAR>, when you had no health coverage from any source? <If Yes to Q1> For how many months in the past year, that is since <MONTH/YEAR>, were you without coverage? Q2. Alternative Q2. <If Yes to Q1> Were you without health coverage at any time in the past six months, that is since <MONTH/YEAR>?
For uninsured respondents:
Q3. Have you ever been covered by any type of health plan? Q4. <IF YES to Q3> When was the last time you were covered by any type of health plan? (CODE Month and year)

This series has several potential advantages to the earlier WSPS coverage history question:

- The suggested questions are tailored based on the current coverage of the respondent, which will make them more salient.
- The suggested questions use a recall period that ends on the day of the survey, and thus is more recent.
- The questions insert dates as memory aides.
- The questions ask respondents for easier-to-recall answers. For example, respondents are asked if they were without coverage in the prior year before being asked for the number of months without coverage. This is a cognitively simpler task. Asking for number of months is complex in any case, and the alternative formulation of Q2 may elicit more accurate responses (but yield less rich data).

If additional data collection resources become available, a longitudinal or panel component could be added to the WSPS. In a panel design a sample of respondents would be re-interviewed periodically.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

For instance, three re-interviews might be done at four-month intervals to capture information about changes in coverage over a year.

Reasons for uninsurance. The WSPS asks respondents to provide the "main reason you do not have health insurance?" Open-ended questions like this one provide data of limited value while asking specific questions about attitudes, values or preferences may yield data of greater value. Focus group work could be used to test which coverage-related attitudes seem most important in coverage decisions among populations in Washington, but the following lists some potentially fruitful attitudes:

- Level of comfort using safety net services (i.e., free or discounted care, public clinics, etc.)
- Level of comfort using the emergency room for routine care
- Level of comfort enrolling in public health coverage
- Belief that physicians will treat even those who cannot afford to pay
- Belief that health coverage is only necessary during episodes of health care need
- Belief that it is easy to obtain coverage when it is needed
- Beliefs that mainstream medical care is often not effective or that self-treatment often is better
- Degree of dislike of using health care or taking medicines
- Belief that one's health is mostly within one's own control (e.g., through better health-related behavior)
- Belief that one's health is a matter of fate (e.g., that illness is "God's will")
- Belief that one's health is largely a matter of random chance
- Level of stoicism (e.g., "I only go to the doctor when things get bad.")
- Perceived propensity to take risks with one's health or finances.

Once the most promising attitudes are identified, simple closed-ended questions can be crafted with scaled answers (e.g., strongly agree, somewhat agree, somewhat disagree, strongly disagree). One drawback of administering such questions in surveys like the WSPS is that they can only be asked of the respondent, and respondents may have systematically different characteristics than other household members. Respondents, however, provide answers that reasonably proxy the attitudes of all family members.

Measuring uninsurance. Measuring health insurance coverage is difficult and there is a lack of expert consensus on the best strategy. Our consultant team agreed that WSPS methods are sound, and should not be changed on the whole. Nevertheless, two points are worthy of consideration.

- The FHIS, then the NSAF, and more recently the CPS, adopted a question verifying lack of insurance coverage. In this scheme, a verification question is asked for each person in the household for whom no coverage is reported. This strategy reduces estimates of the uninsured by a small margin. Whether resulting estimates are more accurate is unknown. Nevertheless, with the adoption of these questions by the Census Bureau in the CPS, verification questions are becoming standard practice. (A verification question has been included in WSPS 2002 which is being fielded February through April 2002.)
- In instances where more than one source of health coverage is identified for an individual in the WSPS, a question about which is the "primary source" is asked. This question is of limited analytic value because individuals generally do not understand complex coordination-of-benefits provisions of health plans. Rather, it may be better for data analysts

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

to impose a hierarchy of coverage, where employer-based is assumed to be the primary payer when such coverage is held, other private coverage is next, and so forth. If this strategy is taken, primary-source-of-coverage questions can be dropped from the WSPS questionnaire, saving a modest amount of interview time.

Improve WSPS Response Rate. There is consensus within the survey research industry that achieving high response rates is becoming more difficult, and as health reform has receded from the national agenda, fewer people are willing to respond to health-related surveys. Nevertheless, compared to other surveys of its type, the WSPS has a somewhat lower response rate than other surveys and the rate declined significantly between 1998 and 2000. Although there is no absolute minimum standard for an acceptable response rate, the 2000 rate was below 50 percent, which leaves considerable room for non-response bias.

Although strategies for improving response rates can be quite costly, there are several promising avenues that could be considered:

- paying respondents monetary incentives to participate (either initially, for answering machine messages, or for refusal conversion). Unfortunately paying response incentives is costly (e.g., a $25 response incentive for 7,000 respondents would cost over $175,000 plus administrative costs), although most non-federal health surveys now do so. One cost-saving option is to pay incentives only to reluctant cases for "refusal conversion," but this strategy can be risky if it becomes known that some respondents are being paid while others are not.
- using professional interviewers (especially for convincing reluctant respondents to participate), and
- lengthening the survey field period. Under this strategy, the number of times sampled households are contacted would be increased to 15 or more. Cases where potential respondents appear reluctant to participate, but do not refuse to do so outright, can be set aside for several weeks prior to re-contact. This approach is less irritating to respondents and may reduce contacts during times during which participation can be particularly difficult. WSPS sponsors may wish to conduct small-scale, randomized response rate experiments to determine the most cost-effective means of improving response rates.

Another strategy for improving response rates over time, which can also cost-effectively enhance the precision of estimates, is to re-interview respondents from one round of the WSPS in the next round. Persons interviewed once are generally considerably more willing to participate in a second round of the survey than are new contacts. The CTS and NSAF use this method. The re-interview group consists of households that stayed at the same address from one survey to the other. However, this approach has drawbacks that need to be considered:

- the resulting sample cannot be used for longitudinal analysis because it is not representative of the wider population and new households are also recruited to the sample in each wave.
- although potentially cost-effective, this strategy requires complex sampling design and data weighting strategies and advanced analysis software.

Reduce Telephone Non-Coverage Bias. The WSPS is conducted by telephone. Households without phones have systematically different health-related characteristics than those with phones, which can lead to bias of survey estimates based only on telephone interviews. Many telephone surveys, including the NSAF and CTS, include small face-to-face interview samples for groups without telephones. This strategy may be effective in reducing bias that results from excluding

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.

households without telephones but it is expensive. An alternative, more cost-effective strategy, is to adjust survey estimates based on respondents' telephone coverage history. The adjustment is accomplished by adding one more question to the survey about telephone coverage history, then "up-weighting" households with recent gaps in telephone coverage. Since households without phones in the recent past are very much like households without telephones during survey data collection, this strategy effectively compensates for excluding the latter group from the survey sample.

* The consultant deliverables containing this information are currently under review. Changes and refinements may occur so caution should be exercised using this draft product.